DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT AND INDEPENDENT AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2005

TUESDAY, APRIL 6, 2004

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:02 p.m., in room SD–192, Dirksen Senate Office Building, Hon. Christopher S. Bond (chairman) presiding.

Present: Senators Bond, Shelby, Domenici, Stevens, Mikulski, and Leahy.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY

ACCOMPANIED BY:

JONATHAN B. PERLIN, M.D., DEPUTY UNDER SECRETARY, HEALTH
VICE ADMIRAL DANIEL L. COOPER (USN RET.), UNDER SECRETARY, BENEFITS
JOHN W. NICHOLSON, UNDER SECRETARY, MEMORIAL AFFAIRS
WILLIAM H. CAMPBELL, ASSISTANT SECRETARY, MANAGEMENT
D. MARK CATLETT, PRINCIPAL DEPUTY ASSISTANT SECRETARY, MANAGEMENT
RICHARD GRIFFIN, INSPECTOR GENERAL

OPENING STATEMENT OF SENATOR CHRISTOPHER S. BOND

Senator BOND. The Subcommittee of VA, HUD, and Independent Agencies will come to order. Senator Mikulski has been temporarily delayed, but she is on her way and asks that we go ahead.

This afternoon we conduct a budget hearing on the fiscal year 2005 budget for the Department of Veterans Affairs. I welcome back the Secretary of the VA, Tony Principi. Mr. Secretary, we are very pleased to have you today. We appreciate your hard work, your commitment and your compassion as the Secretary of VA. In my humble opinion, for what it is worth, your record identifies you as the finest VA Secretary I have ever worked with and we are proud to have your leadership.

As you know, there has been a tremendous amount of attention on the VA and veteran issues in recent months. This is no surprise given the deployment of our military around the world to fight the global war on terror and the war in Iraq. Today hundreds of thousands of brave servicemen and women are deployed across the

globe in such unstable regions as Afghanistan, Iraq, Kosovo, Bosnia, and Haiti. Unfortunately, some of these men and women will return to the States with physical, mental, and spiritual wounds that can never be fully healed. The VA was created with the central purpose of being a safety net for our veterans, and its mission today is probably more important than ever. From what I have seen, we are saving more lives on the battlefield, but often the lives saved are lives of people who have very severe injuries.

Overall, I strongly believe you, Mr. Secretary, have done an outstanding job in meeting the changes and the challenges of serving our Nation's veterans. Veterans have no better ally or friend than you. As a veteran yourself and a father of two sons currently serving in the military, no one can question or criticize your commitment or compassion for our Nation's veterans. As the Secretary of VA, more veterans are served than ever before. During your 3 years as Secretary, the number of veterans enrolled in the medical care system has grown by 2.4 million people and the medical care budget has grown by some $7.3 billion.

You have rightly refocused VA's health care system to give priority service to our most needy veterans. You have begun a new program that allows some veterans to fill privately written prescriptions at the VA. You have reduced the number of veterans waiting more than 6 months for an appointment from 300,000 to less than 20,000, and I expect this waiting list will be eliminated within the next month. You have reduced VA's inventory of benefit claims by almost 100,000 and you have reduced the average processing time from 233 to 187 days. And you have made great strides in expanding burial space. More important perhaps, you have begun the critical process to modernize and rebuild the veterans' health care system that will ensure access and quality of care for future generations of veterans, as well as the current ones. It is an outstanding record and we congratulate you.

Nevertheless, we still face major challenges, namely, providing timely quality care for veterans. During our first budget hearing, I told Senator Mikulski I felt like we were in the movie "Groundhog Day" because our main VA–HUD priorities are underfunded year after year and this year is no exception. By far the most troubling is veterans medical care funding. The budget request underfunds VA medical care and proposes to make up for the shortfall by proposing once again to charge new fees on veterans seeking care, which are essentially a new tax imposed on veterans. These budget proposals were unacceptable last year to the Congress and I can almost certainly assure you they are unacceptable again this year. We should not be balancing our books on the backs of veterans.

VA medical care is a top priority again of this committee. I am committed to ensuring our veterans are not shortchanged, especially in time of war. While on duty, we expect our brave service members to face dangers on a daily basis. They, however, should not expect to face the danger of inadequate medical care services when they return from duty.

I have seen firsthand the scars of combat with visits to the Walter Reed Army Medical Center here in DC. I had the privilege of meeting injured soldiers like Phillip Ramsey from Kansas City,

Missouri who recently returned from combat in Iraq. It really saddens you to see a young man, any young person, with such a personal sacrifice for our country. But I am very pleased with the care that the Department of Defense was providing to him. But we know that Phillip is going to face a lot more challenges when the military discharges him from the service and VA enrolls him in their system. We cannot let soldiers like Mr. Ramsey fall through the cracks.

Mr. Secretary, you are at the center of a perfect storm due to the overwhelming demand for VA health care services. As I discussed last year, this storm was created by a convergence of factors mainly created by Congress with legislation that opened up health care eligibility to all veterans and expanded benefit packages to many. Prior to the enactment of these laws, the VA mainly served the most vulnerable veterans, veterans with service-connected disabilities, with low income, and veterans needing special services, otherwise known as the VA's core constituents. The authors of the 1996 act predicted that the cost of opening up eligibility would be budget neutral because there would be few new enrollees. Wow, did they miss that. Reality, however, has demonstrated the opposite as veterans seeking care have besieged the VA. Since 1996, the number of veterans served by the VA has grown from 2.7 million to 4.7 million in 2004. Let me repeat myself. Since 1996, the number of veterans served has gone from 2.7 million to 4.7 million. And VA projects this growth to continue well into the future.

To respond to this fast-growing workload, we have worked on a bipartisan basis to appropriate substantial funding increases for VA medical care. The account has grown from $16.5 billion in 1996 to almost $28.3 billion in 2004. That is a staggering 71.5 percent. During the last 3 years alone, VA medical care has grown by some $7.3 billion, or 34.7 percent. These massive funding increases have resulted in more veterans being served and provided with improved quality and accessible care. These additional resources have allowed the VA to reduce significantly the number of veterans waiting for service. Nevertheless, the workload growth continues to overwhelm the VA and some veterans, including the core constituents, are still being asked to wait for care. I still believe that is unacceptable.

Further, while the VA has made significant progress in improving its performance in seeing all patients within 30 days, recent data indicate that the VA is only able to see 48.1 percent of new patients within 30 days. That is not good enough and we are not out of the storm yet.

Mr. Secretary, you have taken some significant steps to respond to the overwhelming demand such as prioritizing care for VA's core constituents and implementing the transitional pharmacy benefit program. You have made some unpopular but necessary decisions to suspend the enrollment of lower priority veterans, the so-called Priority 8's. We would all like to be able to serve more but the truth is you cannot serve everyone with the resources available and VA's central purpose is to provide the care for the core constituents.

In order to get out and stay out of the perfect storm, we need to continue to provide VA with adequate resources. The budget re-

quest includes $32.07 billion for discretionary spending. That level is $1.18 billion, or 3.8 percent more than fiscal year 2004. For medical care, the budget request includes $29.2 billion, a $904 million increase over 2004.

I recognize and credit the administration for the significant budget increases during the past 3 fiscal years, but the 2005 request is simply inadequate. The inclusion of new enrollment fees and increased co-payments is especially troubling and disappointing since Congress rejected them last year. I regard the budget request for medical care as a floor, but there is a ceiling due to our other compelling needs such as affordable housing, clean water, and scientific research.

Further, it is clear that the funding level increases for VA medical care cannot be sustained without reform of the system. A critical component of the system is the Capital Asset Realignment for Enhanced Services, or CARES. I fully support CARES. It is critical in ensuring VA has the right facilities in the right places. We still hark back to the GAO report that VA is wasting $1 million a day on unnecessary and under-utilized medical facilities. That money could be converted into direct medical care for 200 new veterans a day.

You set out on an ambitious 2-year plan to emphasize CARES nationally. I appreciate your willingness to listen and respond to concerns of Members of Congress. I also recognize the hard work done by the Honorable Everett Alvarez who reviewed the draft plan and submitted a report last month that addressed most, if not all, of the major concerns expressed by Members of Congress.

Despite your progress and efforts, some members still oppose CARES and they try to portray it as an effort to hurt veterans. This is disturbing to me because I think they have misinterpreted, either out of ignorance or intentionally, the purpose of CARES. It is not a cost-cutting proposal. And it is wrong and unnecessary to worry affected veterans. I urge you to get the truth out about CARES. Everybody needs to understand. It is a most ambitious effort the Federal Government is making to meet the needs of our current veterans.

The truth about CARES is that it will improve access and quality of care. It will result in the construction of new hospitals, new clinics, and nursing homes. Under it, the Federal Government will invest billions of dollars in construction projects and currently you have up to $1 billion available to spend in construction funds, and you could make substantial down payments on new hospitals, new renovation projects, and new outpatient clinics. These are good stories.

Change is difficult but the VA's health care delivery system for serving our veterans is necessary and vital. I believe that CARES will be a major part of your legacy because of its positive effects.

And as I said, I am fully committed to funding the health care needs of the VA core constituents. We need to ensure accountability in performance at the VHA and manage its resources responsibly and efficiently. Veterans from Missouri and across the Nation have told me about wide performance variations that exist among and even within the 21 VISN's. The President's Task Force on Improving Health Care last May said the VISN structure alters the ability

to provide consistent, uniform national program guidance in the clinical areas, the loss of which opportunities for improved quality, access, and cost effectiveness. PTF recommended structure and process of VHA should be reviewed and I agree.

One last item to discuss. Last Tuesday's edition of the local paper had an article entitled "Soldiers of Misfortune", describing the plight of local homeless veterans. I am appalled that some quarter of a million veterans on any given night in this Nation are homeless. You assumed the chair recently of the Interagency Council on Homelessness. I would like to hear how you plan to address this problem.

I look forward to our continued working relationship in addressing the needs of veterans. It is going to be a rough year. It is obviously clear that it would be much rougher for our Nation's veterans if you were not at the helm of the VA. You have my personal confidence. I thank you for your personal attention and responsiveness to the veterans in my State and around the country.

PREPARED STATEMENT

I now turn to my colleague and ranking member, Senator Mikulski, for her statements and comments. Welcome, Senator.

[The statement follows:]

PREPARED STATEMENT OF SENATOR CHRISTOPHER S. BOND

The subcommittee will come to order. This afternoon, the VA–HUD and Independent Agencies Subcommittee will conduct its budget hearing on the fiscal year 2005 budget for the Department of Veterans Affairs. I welcome back the Secretary of VA Tony Principi to our subcommittee. Mr. Secretary, I am very pleased to have you here today. I appreciate your hard work, commitment, and compassion as the Secretary of VA and in my humble opinion, your record will identify you as the finest VA Secretary ever.

Mr. Secretary, there has been a tremendous amount of attention on the VA and veteran issues in recent months. This is no surprise given the deployment of our military around the world to fight the global war on terror and the war in Iraq. Today, hundreds of thousands of our brave service men and women are deployed across the globe in such unstable regions as Afghanistan, Iraq, Kosovo, Bosnia, and Haiti. Unfortunately, some of these men and women will return to the States with physical, mental, and spiritual wounds that can never be fully healed. The VA was created with the central purpose of being a safety net for our veterans and its mission today is probably more important than ever.

Overall, I strongly believe that you, Mr. Secretary, have done an outstanding job in meeting the challenges of serving our Nation's veterans. Veterans have no better ally or friend than you, Mr. Secretary. As a veteran yourself and a father of two sons who are currently serving in the military, no one can question or criticize your commitment or compassion for our nation's veterans. As the Secretary of VA, more veterans are being served than ever before. During your 3 years as Secretary, the number of veterans enrolled in the medical care system has grown by 2.4 million and the medical care budget has grown by some $7.3 billion. You have rightly refocused VA's health care system to give priority service to our most needy veterans. You have begun a new program that allows some veterans to fill privately-written prescriptions at the VA. You have reduced the number of veterans waiting more than 6 months for an appointment from 300,000 to less than 20,000 and this waiting list will be eliminated within the next month. You have reduced VA's inventory of benefit claims by almost 100,000 and reduced the average processing time from 233 days to 187 days. You have made great strides in expanding burial space. Most importantly perhaps, you have begun the critical process to modernize and rebuild the VA health care system that will ensure greater access and quality care for current and future veterans. Mr. Secretary, your record is simply outstanding and I congratulate you.

Nevertheless, you still face major challenges—namely, providing timely, quality health care for veterans. During our first budget hearing, I told Senator Mikulski

that I felt like we were in the movie "Groundhog Day" because our main VA–HUD priorities are under-funded year after year and this year is no exception. By far, the most troubling problem is veteran medical care funding. The budget request underfunds VA medical care and proposes to make up for the shortfall by proposing again to charge new fees on veterans seeking care, which are essentially a new tax imposed on our veterans. These budget proposals were unacceptable last year to the Congress and they clearly are unacceptable again this year. We should not balance our books on the backs of our veterans.

VA medical care is my top priority area again this year and I am committed to ensuring that our veterans are not short-changed, especially in a time of war. While on duty, we expect our brave service-members to face dangers on a daily basis. They, however, should not expect to face the danger of inadequate medical care services when they return from duty.

I have seen first-hand the scars of combat with visits to the Walter Reed Army Medical Center, here in the District of Columbia. I had the privilege of meeting injured soldiers like Phillip Ramsey from Kansas City, Missouri who recently returned from combat in Iraq. It deeply saddens me to see such a young man make such a personal sacrifice for our country. I was pleased with the care that the Department of Defense was providing to him but we know that Phillip will face more challenges when the military discharges him from service and the VA enrolls him into their system. We cannot let soldiers, like Mr. Ramsey, fall through the cracks.

Mr. Secretary, you are at the center of a "Perfect Storm," due to the overwhelming demand for VA health care services. As I discussed last year, this storm was created by a convergence of factors, mainly created by the Congress with legislation that opened up health care eligibility to all veterans and expanded benefit packages to many veterans. Prior to the enactment of these laws, the VA mainly served the most vulnerable veterans—veterans with service-connected disabilities, veterans with low-income, and veterans who need specialized services—otherwise known as VA's core constituents. The authors of 1996 Act predicted that the cost of opening up eligibility would be budget neutral because there would be few new enrollees. Reality, however, has demonstrated the opposite as veterans seeking care have besieged the VA. Since 1996, the number of veterans served by the VA has grown from 2.7 million to 4.7 million in 2004. Let me repeat that: Since 1996, the number of veterans served by the VA has grown from 2.7 million to 4.7 million in 2004. Further, the VA projects this growth to continue well into the future.

To respond to this fast growing workload, we have worked on a bipartisan basis to appropriate substantial funding increases for VA medical care. In fact, the VA medical care account has grown from $16.5 billion in 1996 to almost $28.3 billion in 2004. That is a staggering 71.5 percent increase! During the last 3 years alone, VA medical care has grown by some $7.3 billion or 34.7 percent. These massive funding increases have resulted in more veterans being served and provided with improved quality and accessible care. Further, these additional resources have allowed the VA to reduce significantly the number of veterans waiting for services. Nevertheless, the workload growth continues to overwhelm the VA and some veterans—including VA's core constituents—are still being asked to wait for care. That is unacceptable. Further, while the VA has made significant progress in improving its performance in seeing all patients within 30 days, recent data indicates that the VA is only able to see 48.1 percent of new patients within 30 days. That too is unacceptable. We are clearly not out of the storm.

Mr. Secretary, you have taken some significant steps to respond to the overwhelming demand for VA health care such as prioritizing care for VA's core constituents and implementing a transitional pharmacy benefit program for veterans on the waiting list. You also made the unpopular but necessary decision to suspend enrollment of lower priority veterans who have higher incomes and no service-connected disabilities—the so-called Priority 8s. Of course, all of us would like the VA to serve more veterans, including the Priority 8s, but the truth of the matter is that the VA cannot be everything for everyone, especially when the VA still has a long ways to go in meeting the needs of its core constituents. I emphasize that the VA's central purpose is to provide timely, accessible, and quality health care for its core constituents. There can be no compromise on this purpose. These men and women rely on VA's health care system. They have nowhere else to go.

In order to get out and stay out of the "Perfect Storm," we clearly need to continue to provide the VA with adequate resources. The administration's budget request proposes $67.27 billion for the VA, including $32.07 billion for its discretionary programs. The discretionary funding request is $1.18 billion or 3.8 percent more than the fiscal year 2004 enacted level. For medical care, the budget request includes $29.2 billion budget for medical care—a $904 million increase over the fiscal year 2004 level. I recognize and credit the administration for the significant budget in-

creases during the past 3 fiscal years but the fiscal year 2005 request is simply inadequate. The inclusion of new enrollment fees and increased co-payments is especially disappointing, especially since the Congress rejected them last year. Thus, I regard the budget request for medical care a floor but there is a ceiling due to our other compelling needs such as affordable housing, clean water, and scientific research. Further, it is clear that the funding level increases for VA medical care cannot be sustained without reform of the system.

A critical component of reforming the VA medical care system is the Capital Asset Realignment for Enhanced Services or "CARES" initiative. The budget provides a substantial investment of $524 million to implement the CARES program. I fully support CARES because we cannot continue to pour resources into hospitals that are half-empty or exist primarily to serve the research and financial interests of medical schools. Further, CARES is absolutely critical in ensuring that the VA has the right facilities in the right places so that more veterans can be served on a timely basis. According to the General Accounting Office, the VA is wasting $1 million a day on unnecessary and underutilized medical facilities. These funds are being paid out of VA's medical care account. Thus, instead of wasting $1 million a day on empty buildings, the VA could provide direct medical care to 200 new veterans a day. Obviously, VA must maximize its funds on meeting its first and foremost mission of caring for our Nation's veterans. That is why CARES is so critical and urgently needed.

Mr. Secretary, you initiated an ambitious schedule 2 years ago to develop a national CARES plan. The process has not been easy but I believe that you have made tremendous progress. I especially appreciate your willingness to listen and respond to the concerns of veterans and Members of Congress. I also recognize the hard work done by the 16-member CARES Commission, led by the Honorable Everett Alvarez, who reviewed the Draft Plan and submitted a report last month that addressed most, if not all, of the major concerns expressed by members of Congress and veterans.

Despite your progress and efforts, some members of Congress and stakeholders still oppose CARES. Sadly, some portray CARES as an effort to hurt veterans. I am frankly disturbed by these sorts of characterizations. For example, some folks in the media have portrayed CARES as a cost-cutting proposal. This is simply wrong and it unnecessarily incites fear and stress among our affected veterans. Mr. Secretary, I urge you to get out the truth about CARES. The public and stakeholders need to understand that CARES is the most ambitious effort the Federal Government is making to meet better the needs of our current veterans; and, because of the lack of space currently available, it will allow the VA to meet the exploding demand for medical care from future veterans.

The truth about CARES is that it will improve access and quality care for our veterans. The truth about CARES is that it will result in the construction of new hospitals, new clinics, and new nursing homes. The truth about CARES is that it will modernize and address safety and seismic problems at existing hospitals to ensure patient safety. The truth about CARES is that the Federal Government will invest billions of dollars in construction projects, which will boost local economies and create jobs. The last point I emphasize is that you currently have up to $1 billion in construction funds available to spend now. With these funds, you have the opportunity to make a substantial downpayment on new hospitals, new renovation projects, and new outpatient clinics throughout the nation. These are good stories.

Change is difficult but in the case of the VA's health care delivery system and for serving our veterans, it is necessary and vital. The future of VA's health care delivery system depends on a modernized infrastructure system that is located in areas where most of our veteran population lives. Many VA buildings were built after World War II and are not all configured for modern health care delivery and some are no longer appropriately located. If we expect today's service-members to fight with modern equipment and weapons, then why can't we expect our veterans to be provided with health care service in modern facilities?

Mr. Secretary, CARES is your biggest challenge today and I am confident you will make the right decisions. I believe that CARES will be a major part of your legacy because of its far-reaching and longstanding positive effects. I am committed to CARES and committed to funding it so that we can begin to address as much of VA's infrastructure needs as quickly as possible and without delay.

As I said earlier, I am also committed to funding fully the health care needs of VA's core constituents, however, let me say this clearly: addressing the health care needs of our veterans is more than a funding matter. As I just discussed, CARES is a critical component in addressing health care for veterans. Further, management and accountability cannot be ignored. With your leadership, Mr. Secretary, the VA has made some significant strides in its management, but clearly, much more needs

to be done. VA especially needs to ensure greater accountability and performance consistency at the Veterans Health Administration (VHA) and manage its resources more responsibly and efficiently. Veterans from Missouri and across the Nation have told me about the wide performance variations that exist among and even within the 21 Veterans Integrated Service Networks or "VISNs." In fact, the President's Task Force on Improving Health Care Delivery for VA and DOD (PTF) found last May that the "VISN structure alters the ability to provide consistent, uniform national program guidance in the clinical arena, the loss of which affects opportunities for improved quality, access, and cost effectiveness." Due to these findings, the PTF recommended "the structure and processes of VHA should be reviewed." I agree.

Before closing, I raise one more issue that continues to trouble me—homeless veterans. Last Tuesday's edition of the Washington Post contained an article titled "Soldiers of Misfortune." The article described the plight of local homeless veterans and their challenges. I am appalled that there are still some 250,000 homeless veterans on any given night in this Nation. Mr. Secretary, you recently assumed the chair of the U.S. Interagency Council on Homelessness. I would like to hear how you plan to address this problem.

Mr. Secretary, I look forward to our continued working relationship in addressing the needs of our veterans. This is going to be a rough year—perhaps the most difficult year during your tenure. However, it is obviously clear that it would be much rougher for our Nation's veterans if you were not at the helm of the VA. You have my personal confidence because you have already made many long-lasting and meaningful changes to the VA that will benefit millions of current and future veterans for years to come. I also thank you for your personal attention and responsiveness to the veterans in my home State of Missouri. Your recent visit to Mt. Vernon, Missouri with me was much appreciated.

I will now turn to my colleague and ranking member, Senator Mikulski for her statement and any comments.

STATEMENT OF SENATOR BARBARA A. MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman.

Mr. Secretary, I am very pleased to welcome you. This is your fourth year in testifying before this subcommittee and, of course, you also served another Bush administration. I want to thank you and the people who work for you and all of those who staff our VA facilities for the work that they do.

I particularly want to say thank you for the quick response we got on the VA outpatient clinic at Fort Howard. When Maryland was hit by Hurricane Isabel, the VA outpatient clinic was absolutely devastated and we were told by the locals that it would take 18 months to repair. Your quick response really helped us and now it is open. I will tell you if you toured that community around there, they were terribly hit. So we want to say thank you for your responses on Fort Howard, as well as on Perry Point. You and I are in absolute agreement on the direction to go. So thank you.

We have such great respect for you, Mr. Secretary. You are a combat-decorated Vietnam vet. You continue to serve your country. You remember the lessons learned from one war and how we need to continue to serve not only our veterans of other wars, but those men and women who are now returning from the Afghan and Iraqi conflicts.

While you served your country battling against enemies, we know that you are now arm wrestling with OMB over the budget, and your appearance before the authorizing committee really outlined how spartan this budget is.

First of all, know that I am going to associate myself with the remarks from the chairman and know that I have always had two principles for the VA's budget. No. 1, the promises we made to our veterans need to be promises kept, while also making the best use

of the taxpayers' dollars. We need to make sure that we do not have waiting lines for veterans. No. 2, issues like membership fees if you are a category 7 or increased co-payments really do not work. I am concerned that this budget falls short on these principles.

We will be able to talk about many of the issues, but we do want to acknowledge some of the good things in this budget. We want to say thank you for reducing the financial burden on former POW's, also on our terminally ill veterans, and also on our poorest of the poor veterans. These are very good ideas and we want to work with you to support those, and you have been a real advocate in this area.

But what we are concerned about is, No. 1, the whole issue of both the money and the outcomes. I understand that you told the VA authorizing committee that you needed $1.2 billion more, but unfortunately, OMB did not hear you. But we hear you and we have got to figure out how to give you the resources you need. I am very concerned in the area of shortages, I know that one of our outpatient clinics in the Glen Burnie area is full. We understand that blind veterans now do not have access to rehab programs. These are of great concern to us.

Now, we have worked on a bipartisan basis to increase VA funding every single year, and we need to continue to do that. But OMB continues to shut out Priority 8 veterans and wants to implement fees. I am not going to go over what the President's summary does in the interest of time, but you need to know I am concerned about a $250 annual user fee, as well as prescription drug co-payments. I look forward to hearing your comments on that. I also look forward to hearing about the demonstration project you initiated that where someone sees a primary care doctor and has a bona fide prescription, say, to manage cholesterol or diabetes, that they could get it filled at the VA without having to see a VA doctor. We want to make sure we prevent waste and abuse, but also I think your own estimate said this could be a new way to reduce the stresses on our medical profession. We want to know about that and how are we doing with the prescription drug benefit and how you are managing it. How are you getting discounts? How is it working for you?

Again, I mentioned the waiting lines. The Blind Veterans Association told our staff that there are over 2,000 veterans waiting up to 1 year for admission to a blind rehab center. We would like to hear your comments on that, whether you believe that is accurate, but particularly for those who have truly been disabled because of the permanent and irrevocable wounds of war, what can we do. That will also take me to talking about our Iraq men and women.

We are concerned also about another waiting time, which we have been working on for over a decade, in claims processing. We want to know the status. Have we reduced the waiting time and the waiting lines? We understand that in this budget we are talking about reducing over 500 staff in the Benefits Administration. This work to reduce the claims processing has been such a longstanding one that started with the VA–HUD Subcommittee under Bush One, Clinton, and now you. We would hope that just as we get it on track, we are not having a self-imposed derailment of the progress that has been made.

Also, we are concerned and puzzled by how OMB continues to insist that VA medical funding be focused on outsourcing studies. We know that our subcommittee rejected a $75 million outsourcing study, and we understand that OMB is trying it again and we will be discussing this with you.

When we take a look at our returning Afghan and Iraq veterans, we want to be sure that we are ready for them. They are coming back with new types of injuries. For those of us who have been to Walter Reed, it is tough. I do not have to tell you and others at the table how tough it is. They have been injured in body, in mind, and in spirit. We have to make sure, when they leave Walter Reed and go back to the community, we are ready to receive them. We understand that the prosthetic injuries are significant and severe because of the types of attacks after the battle of Baghdad. Therefore, we are interested in where we are on meeting those kinds of needs but also in the area of research.

We know that research has had a bit of a rocky road during this last year, and yet we believe that it is in VA medical research which often gives such practical research in patient care, patient rehabilitation, breakthroughs in new technologies that are truly rehabilitative that will benefit our veterans who have been so severely injured and at the same time, it will ultimately benefit the larger American population who will face this.

These are the types of things we look forward to having a discussion with you about. We thank you and your team at the table.

Senator BOND. Thank you very much, Senator Mikulski.

Since our chairman of the full committee is here——

Senator STEVENS. Senator Shelby was here first.

Senator BOND. All right. Senator Shelby was next in line.

Senator SHELBY. I will defer to the chairman, if he wants to.

Senator STEVENS. No.

Senator BOND. Everybody is doing that these days.

Senator SHELBY. Absolutely.

Senator BOND. It makes a lot of sense.

Senator SHELBY. It makes a lot of sense to all of us members, does it not?

Senator BOND. Yes. We each get a point. Thank you.

STATEMENT OF SENATOR RICHARD C. SHELBY

Senator SHELBY. Thank you, Senator Bond. Thank you, Mr. Chairman.

I ask first that my entire statement be made part of the record.

Senator BOND. Without objection.

Senator SHELBY. And I have a few comments. I will try to be brief.

Mr. Secretary, welcome to the committee. We all appreciate you personally, but more than that, we appreciate what you and your staff do. You are a very principled Secretary.

Your testimony, Mr. Secretary, points to a number of different initiatives that are underway within the VA to improve the benefits claim process. I applaud the work you and your staff have done to reform this system and will support you as you continue this work.

I am pleased to see funding requested in this budget for the virtual VA project, compensation and pension evaluation redesign project, the training and performance support systems project, and the veterans service network. Would you discuss in your testimony the tools these programs will give you to improve the claims process and how this budget helps you to accomplish your goals there? We all know you continue to face challenges in the claims area, and based on the correspondence that I receive as one Senator, some of these challenges are basic and fundamental. Customer service seems to be a persistent problem.

I have seen two very recent examples. These are representative of a large majority of the letters I get from veterans about their experiences with the Montgomery, Alabama VA regional office.

COMPENSATION AND PENSION CLAIM PROCESS

One gentleman went to the Montgomery regional office to inquire about disability benefits he might qualify for and establish a claim in December of 2003. He refiled the same claim four times in less than 3 months because it continued to be lost. Once he returned to follow up 2 hours after having refiled and was told there was no record of his claim.

Secondly, a lady wrote the Montgomery regional office on January 27 about DIC benefits. To date she has received no response.

A common refrain I hear is that "the mission of the VA regional office seems to be to make the process as difficult, confusing, and frustrating as possible to discourage anyone from seeking benefits or compensation." I know that is not your tone and that is not your mission. But how do we overcome this?

MEDICAL RESEARCH

The VA's own document, getting into medical research now, Appropriation Requirements by Strategic Goal, indicates a need for 2005 funding at $460 million for the direct cost of the VA research program, the same level recommended by the independent budget and the friends of VA medical care and health research. The budget request is $20 million below last year's level of $405 million. I am concerned about this funding cut. Would you discuss that during your research funding discussion?

I also see that VA anticipates very large increases in the amount of non-VA Federal and private funding for VA researchers, $60 million and $50 million, respectively, a 14 percent increase in non-VA sources. Why the sharp increase next year when you only anticipate a 4 percent increase this year? Is it really appropriate to put the VA in the position of depending on other agencies or the private sector to fund research important to veterans?

During the time of war, which we are in now in Iraq, and one that is generating large numbers of injuries, Mr. Secretary, if you are not already, should you not be looking to increase rather than reduce the research program? If VA research is funded at the requested level, what areas of research will be cut? We would be interested in that. If provided with additional funding, what areas of research would VA add or expand? I believe these are relevant questions.

And now concurrent receipt. To what extent is the VA working with DOD to implement the concurrent disability payment and combat-related special compensation programs? This CDP and CRSC program workload has not had a negative impact on the claims operations I hope.

PREPARED STATEMENT

Mr. Chairman, I know those are a lot of questions and I hope the Secretary will see fit to discuss these during his time to talk. Thank you.

[The statement follows:]

PREPARED STATEMENT OF SENATOR RICHARD C. SHELBY

The President has requested $67.7 billion for the Department of Veterans Affairs for fiscal year 2005. This includes $35.6 billion for entitlement programs and $32.1 billion for discretionary programs.

The fiscal year 2005 request for VA Medical Care is $27.1 billion, and it also projects $2.4 billion in collections. This is a 4.1 percent increase over the fiscal year 2004 enacted level. Given the increase in the number of veterans using the VA health care system, I am pleased to see this increase but strongly feel the VA needs greater resources to adequately meet the health care needs of our deserving veterans. Experts agree, including the VA's own Undersecretary of Health in testimony given last year, that the VA needs funding increases on the order of 15 percent a year to maintain current medical care services.

I am disappointed this budget cuts funding for VA Medical and Prosthetic Research. The direct cost and research support accounts are both funded at $384.7 million, a $20 million and $30 million cut respectively. I believe these cuts are harmful to the VA's core mission of providing the best medical care possible to our veterans. I plan to address this issue with Secretary Principi and hope the subcommittee will take action in the fiscal year 2005 bill to provide additional funding for both VA Medical Care and VA Medical and Prosthetic Research.

While, in my opinion, this budget again falls short in total funding for our veterans, it does include important initiatives like the Capital Asset Realignment for Enhanced Services (CARES) program that will take major steps to construct new facilities across the country to improve access for our veterans. This budget includes $1.2 billion for benefits management as well as a number of programs that seek to continue this administration's efforts to improve and streamline the veteran's benefits claim process. It also includes $455 million to improve the VA burial program. Eighty-one million dollars is provided for cemetery construction, expansion and improvement. I am pleased that advanced planning funding is included for a new national cemetery in Birmingham.

I look forward to working with Chairman Bond and Senator Mikulski on this bill and will continue to do everything I can to support the VA and our veterans in Alabama and across the Nation.

Senator BOND. Thank you, Senator Shelby.

Chairman Stevens.

STATEMENT OF SENATOR TED STEVENS

Senator STEVENS. Thank you very much, and I would ask that my complete statement appear in the record, Mr. Chairman.

Senator BOND. Without objection.

Senator STEVENS. It is nice to be with you again, Secretary Principi, and your colleagues. I am aware of the recent VA-released report called Capital Asset Realignment Enhanced Services, which I understand you call CARES, which recommends the reallocation of capital assets necessary to meet the demand of veterans' health care over the next 20 years.

VA LEASES IN ALASKA

The commission reviewed the VA leases in Anchorage that are due to expire in 2007 and the Army provided space at the Bassett Army Community Hospital in Fairbanks. It is my understanding that the report proposes a joint venture between the VA and the Air Force to construct a new building next to the Elmendorf Hospital and the report also discussed VA space for the Bassett Army Community Hospital in Fairbanks. Upon completion of that new facility, the VA outpatient clinic will gain an additional 1,100 square feet for a total of 3,000 square feet as part of the construction, which is very much needed in the interior of Alaska.

I do hope that you will join us in moving ahead with some of these projects. I keep hearing from veterans in Alaska regarding their concerns over the funding of veterans health care. We all do here in the Congress, and I think this committee hears more than anyone about it. We will do all we can to maximize funds for health care in 2005 and work with you in that regard. Until the new Medicare legislation is fully implemented in 2006, many senior vets are turning to the VA as an alternative source of medical coverage partially due to the prescription drug benefit, a problem that is addressed by our new bill but will not really crank in to providing real assistance until 2006. I would ask that you take a look at the problems that are listed in my comments concerning the State as a whole, Secretary Principi.

SOUTHEASTERN ALASKA

I do, in the interest of time, want to ask you to respond to this question. I must go to another hearing. But I am concerned about southeastern Alaska, which was not covered by your report, as I understand it. The regional hospital which is owned by the city and borough of Juneau operates the Juneau Recovery Hospital. It is a State-licensed and accredited 16-bed substance abuse facility. The veterans of the southeast are not covered by the VA for the services they obtain from that Juneau Recovery Hospital, and it is my understanding they must leave Alaska if they seek aid in getting treatment for their alcohol-chemical dependency treatment. I am told that last year that VA told the Juneau Recovery Hospital that it was not interested in contracting for services from that facility and that leaves no alternative for southeastern Alaska veterans but to leave Alaska to fly 900 miles south to obtain treatment.

PREPARED STATEMENT

I think most people do not understand our distances. Mr. Secretary, I know you do and I know that you will do all you can to try to deal with that problem. But clearly, we have I believe the highest per capita population of veterans in our population. Although we are a small population State, we have an enormous number of veterans and they live in very remote areas. It is very difficult to care for them now as they are aging and they need a lot of attention. I would hope that somehow or other we would work out something in terms of this contract care concept and let them have an opportunity to obtain treatment in Alaska. It costs a lot of money to fly to Seattle for a doctor's appointment and it

is just impossible for many of them. Many of them are my age. I know the problems that they face, and I would like to help them if I can.

So thank you very much, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF SENATOR TED STEVENS

Thank you very much, and I would ask my complete statement appear in the record Mr. Chairman.

It's nice to be with you again Secretary Principi. I am aware of the recently released CARES (Capital Asset Realignment for Enhanced Services) report, which recommends the reallocation of capital assets necessary to meet the demand for veterans' health care services over the next 20 years. With respect to Alaska, the commission reviewed the VA leases in Anchorage, due to expire in 2007, and the Army-provided space at the Basset Army Community Hospital in Fairbanks.

The report mentions a proposed joint venture between the VA and the Air Force to construct a new building adjacent to the Elmendorf Hospital. This new facility is expected to increase primary care space by 75 percent, specialty care space by 100 percent, and mental health space by 100 percent.

The report also discusses VA space at the Bassett Army Community Hospital in Fairbanks. The Army is constructing a new hospital facility scheduled for completion in fiscal year 2005. The VA community-based outpatient clinic will gain an additional 1,100 square feet for a total of 3,000 square feet as part of this construction.

With the Alaska Market outgrowing its leased space in Anchorage and continued constraints common to Veterans throughout Alaska, I ask you to join me in ensuring these projects move ahead as expeditiously as possible.

I continue to hear from veterans in Alaska regarding their concerns with the level of funding for Veterans Healthcare. I am fully aware of the funding issues you are currently facing as you run the Nation's largest integrated health care system, and recognize that this is an issue not limited to Alaska. My colleagues and I will do all we can to maximize funds for VA healthcare in fiscal year 2005. However, it is my understanding that there are many individuals who continue to use the VA as a primary source of medical care, even though they have access to alternative sources of medical coverage. I understand this may be partially due to the prescription drug coverage provided by the VA that some plans don't provide. Until the new Medicare legislation is fully implemented in 2006, that is also true for many senior vets. The unnecessary burden this puts on a system already overwhelmed with high priority cases must be an issue worth reviewing.

Last year the VA notified the Alaska delegation that it planned to move the administration of veterans benefits (but not health care) to Salt Lake City, consistent with the implementation of the VAMROC (VA Medical and Regional Office Center) Plan. VA staff in Alaska assured my office that the proposed move would not result in any personnel transfers or layoffs in Anchorage and that the move was intended to result in more efficient and timely processing of claims for veterans benefits. This has been successful.

Alex Spector, Director of the VA in Anchorage, and Douglas Wadsworth, Director of the VA Regional Office in Salt Lake, tell me that the percentage of rating claims pending over 6 months has been reduced from 39 percent to 26 percent, and that as of February, the VA has already successfully rehabilitated 23 veterans through its Vocational and Rehabilitation & Employment Program, compared to a total of 31 veterans in fiscal year 2003.

I thank you again for all your hard work on developing a special physician payment system for veterans' health care in Alaska. Your leadership has preserved access to healthcare for our veterans. That system helped us gain a special physician rate in Alaska for Medicare and TRICARE beneficiaries last year when the Medicare Modernization legislation was enacted.

I am concerned about Southeast Alaska issues that are not covered in the CARES report. It's my understanding that the Bartlett Memorial Hospital, owned by Juneau, operates JRC, state licensed and accredited 16-bed substance abuse facility, providing treatment of alcoholism and drug dependency. JRH offers many services including: intensive outpatient, inpatient rehabilitation, partial hospitalization and continuing care.

One last additional issue I would like to raise is regarding our Veterans in Southeast Alaska. These veterans are not being covered by the VA for services they obtain at the Juneau Recovery Hospital (JRH) and must leave Alaska if they desire the VA to cover their alcohol and chemical dependency treatment. JRH has negotiated

with the VA office in Anchorage since 2002 in order to obtain a contract for services. In March, 2003, JRH was told that the VA was not interested in a contract for services.

This leaves no alternative for Alaskans but to travel 900 miles south to obtain treatment. Most people don't understand our distances in Alaska, and I know you do, and will do all you can to help with this problem.

We have the highest per capita population of veterans, Mr. Secretary, and they live in remote areas, making it difficulty to care for them as they age. I hope we can we work out something in terms of this contract care treatment, so they can obtain treatment in Alaska. Many of them are my age and I would like you to join me in helping them.

Senator BOND. Thank you very much, Chairman Stevens. We appreciate your being here.

Secretary PRINCIPI. If I can, I would like to briefly answer the question. You are absolutely right about this. We have an extraordinary opportunity to share with the Air Force at Elmendorf and with the Army up at Wainwright. It is critically important that we move forward very quickly on the new outpatient clinic at Elmendorf because our lease is expiring and they do not want to renew it because they have to expand. So we have to do that. It is just a great partnership.

The same up at Wainwright. That is coming along well with the new hospital up at Wainwright. We will continue to cement that bond between the military services and the VA in Alaska.

Not as well as you, Senator, I have been to Alaska so many times I understand the extraordinary difficulty of commuting back and forth for veterans, and I will look into that contract in southeastern Alaska to see if there is something we can do to keep veterans close to their home and not have to transport them all the way down to Seattle.

[The information follows:]

CONTRACTING OUT SERVICES FOR SOUTHEASTERN ALASKA VETERANS

Southeast Alaska veterans currently receive primary care both at the VA Clinic located in Anchorage and through fee basis care in their home community. Veterans who are 50 percent service-connected (SC) and higher are authorized for fee care in their home community. Also, any veteran enrolled in the VA system who meets the medical criteria for emergent care, obviating the need for hospitalization, is also authorized care in their home community. Veterans who are less than 50 percent SC, or are non-service connected (NSC), are offered primary care at the VA Clinic in Anchorage. Veterans who meet the VA Beneficiary Travel guidelines are provided travel to Anchorage for appointments.

The Alaska VA Healthcare System had a vendor outreach meeting in Juneau, AK, on April 6, 2004. Thirteen individuals representing nine provider groups were present. A separate meeting occurred with the Family Practice Clinic. The purpose of the outreach was to update vendors about the Alaska fee basis program, answer questions, and talk about possible partnerships with the VA. Although a formal proposal for contracting care was not presented, it did not appear as though any of the participants were particularly interested in contracting with VA, given the quality measures, referral processes, and clinical data requirements required in a healthcare contract with VA.

VA is willing to further explore contracting with providers in Southeast Alaska, as well as pursuing other possible options that would be a cost effective solution and alleviate travel to Anchorage for southeastern Alaska veterans. It should be noted that the availability of specialty care is very limited, not only in Southeast Alaska but throughout the State. VA appreciates the inconvenience to patients who need to travel outside Alaska for care, and attempts to minimize that inconvenience to the extent possible within available resources.

Senator STEVENS. Thank you very much. I am going to offer to take the whole committee to Alaska, and I am going to start at

Ketchikan and put them on a ferry and take them up through southeastern by how veterans get between places because that is the least expensive way to travel. Then I am going to take them up to Anchorage and let them travel by train up to Fairbanks, and then we will fly around in some small planes from village to village to village and let them see how it works.

When Senator McClellan was chairman of this committee, I was a younger Senator. He did that for me and we went up there and spent 10 days and there was not a request I made for the next 2 years that was denied.

Secretary PRINCIPI. Well, we have allocated an additional $10 million to Alaska for contract care in the community because of the needs up there and we will continue to look at it, Senator.

Senator STEVENS. Thank you very much. Thank you, Mr. Chairman.

Senator BOND. Senator Domenici.

STATEMENT OF SENATOR PETE V. DOMENICI

Senator DOMENICI. I was just going to tell Senator Stevens he does not have to take me up there. Whatever you want, you can have. You do not have to take me up on the trip. I have too many other trips to take. Just believe me.

Mr. Chairman, let me just have a couple of minutes and I will insert my remarks.

First, I want to thank you, Mr. Secretary. I think they are saying your name wrong, but they say mine wrong also. I tell them my name is Domenici and they say, no, it is not. It's Domenici. So I have to take them home to Italy and let them talk to my relatives. But your name is Principi.

In any event, let me say I have three issues and I am just going to cover them very quickly.

TELEHEALTH

One has to do with telehealth. As you know, for a long time I have been interested in enhanced access of care for rural veterans. Establishing more community-based outpatient clinics is one way that the VA and Congress have worked together to reach these areas. In fact, my home State of New Mexico now operates 11 such clinics for rural veterans. I believe Congress and the VA should work together to improve the use of technology for serving rural veterans. In particular, we can do much more in the area of telehealth and telemedicine.

What is the current state of the VA telehealth, and what legislative initiatives would you recommend to improve that?

It is my understanding that VA is implementing a telehealth pilot project to provide medical services in remote parts of eastern New Mexico. I would like you to describe that for the record if you do not have it ready, if you would do that for us.

[The information follows:]

TELEHEALTH

VA is recognized as a leader in the field of telehealth. VA's former Telemedicine Strategic Healthcare Group has been incorporated into a new Office of Care Coordination (OCC) and the term telehealth is increasingly being used in VHA rather than

telemedicine. These changes recognize that implementing telehealth is more than a technology issue. It involves embedding telehealth and other associated technologies directly into the care delivery process and that it now involves many different professionals. VA is undertaking telehealth in 31 different areas. OCC is supporting all these areas but is focusing particularly on those where there is particular need. It is therefore designating lead clinicians in the areas of telemental health, telerehabilitation and telesurgery. VA is formalizing guidance for the development of telehealth, with a particular emphasis on the community-based outpatient clinic in relation to major areas of veteran patient need. This has commenced with the following:

—Telemental health,
—Teledermatology,
—Telesurgery (enabling remote pre-op and post-op assessments),
—Teleretinal Imaging for diabetic retinopathy, and
—Telerehabilitation.

Teleradiology is a major associated area of need where VA is seeking to work to bring resources at a local level into an interoperable infrastructure and create a national system. Such a system, if developed, will enable sharing of resources and acquisition of services when local difficulties with recruitment and retention of radiologists create challenges to delivering care. OCC is working to support VHA's Chief Consultant for Diagnostic Services in this endeavor and to make sure that the various areas of telehealth practice harmonize with respect to such processes as credentialing and privileging. This will facilitate working with the Department of Defense.

In recognition of the demographics of the veteran population and the rural and underserved areas in which veteran patients often live VA is placing a particular emphasis on developing care coordination that uses home telehealth technologies. The rationale for this program is to support the independent living of veterans with chronic diseases through monitoring of vital signs at home e.g. pulse, blood pressure etc. at home. A piloting of this care coordination/home telehealth (CCHT) program demonstrated very high levels of patient satisfaction and reduced the need for unnecessary clinic admissions and hospitalizations. For example by monitoring a heart failure patient at home it is possible to detect any worsening of the condition when there is breathlessness and weight gain. Early detection in this way means medication can be adjusted and the problem resolved rather than have the patient deteriorate unnoticed and require admission to hospital in extremis at risk of dying, and often necessitating an intensive care unit admission.

Because the support of a patient at home usually requires a caregiver in the home OCC is paying attention to caregiver issues and working on this collaboratively with other organizations and agencies, as appropriate.

Care coordination is being incorporated into VA's long-term care strategic plan as a means of supporting non-institutional care, when appropriate for veteran patients who want to remain living in their own home and live independently.

At this time we have no specific legislative initiatives to recommend.

TELEHEALTH PILOT IN NEW MEXICO

VA is implementing a telehealth pilot to provide medical services to patients in remote parts of VISN 18. Telehealth is remote patient case management using devices located in the patient's home that connect to hospital staff via a normal phone line. The patient responds to short, disease-specific questions each day. The devices may also be used to transmit vital signs and medical information to hospital staff monitoring the daily reports. Hospital staff can send patients reminders, tips, and feedback on their progress. Telehealth enhances veteran health care because it allows for earlier intervention and enhanced veteran self-care and self-assurance. To begin, selected patients with congestive heart failure and chronic obstructive pulmonary disease will receive telehealth care in their homes. Implementation will begin with the Geriatric Clinic and the Spinal Cord Injury Clinic in Tucson, Arizona, followed by their Primary and Medical Care teams. Then the pilot will be expanded to Amarillo VA Health Care System patients. Amarillo will start enrolling medical center patients with congestive heart failure and chronic obstructive pulmonary disease for care coordination in Phase One. When this is operational, Phase Two will begin to enroll patients with these same diseases at the Clovis, New Mexico, and Lubbock, Texas, community based outpatient clinics. VA anticipates that Phase Two will occur in fiscal year 2005.

STAFFING IN RURAL FACILITIES

Given the increased workload throughout the system, a majority of sites are experiencing an increase in demand for services. This is having an impact on VA's ability to maintain capacity and provide services within its 30-day access standards. Remote rural facilities face even greater challenges in the recruitment of providers, because frequently the pool of providers for recruitment is not as extensive as in nonrural locations. This is especially true for specialists, because many specialty positions are scarce. In some of the small rural facilities, the loss of a specialist can have a major impact on the services provided, resulting in prolonged waiting times and wait lists.

In recent years, VA has improved access to care for veterans in rural areas through development of Community-Based Outpatient Clinics (CBOCs). Where we have staffing shortages, these clinics are managed via contracts. Additionally, VA has a new initiative on care coordination that uses telehealth technology to provide care in patients' homes. Telehealth technologies allow greater access to care for veterans in rural areas, while simultaneously reducing travel and inconvenience. Through telehealth technology, staff at VA medical centers can provide services remotely, thus filling in the void where staffing shortfalls exist.

We do not have readily available, detailed information on staffing shortfalls in specific rural locations. This type of information would fluctuate on a weekly, even a daily basis. Obtaining reliable information would require an extensive survey of field facilities.

We have sent to Congress legislative initiatives that would assist us in recruitment of physicians and nurses, not only in rural locations, but throughout the VA health care system. One is a Physician Pay Bill, which would allow VA to be more competitive in the market for recruiting physicians to work within VA. This is especially true for specialty physicians which VA has difficulty recruiting. The second is a legislative proposal allowing enhanced flexibility in scheduling tours of duty for registered nurses. The ability to offer compensation, employment benefits and working conditions comparable to those available in their community is critical to our ability to recruit and retain nurses, particularly in highly competitive labor markets and for hard-to-fill specialty assignments.

Senator DOMENICI. And then medical research has been touched on a bit. I would just like you to describe in more detail the current trends of medical research and tell us where we might expect some new breakthroughs. We talk about collaboration with other government agencies and universities. I can tell you there are great opportunities for the VA to contract and go into partnership with other branches of the government. I think you know in my home city of Albuquerque, we were the second—and actually the first of a significant partnership of a hospital. Air Force veterans, one big hospital instead of two hospitals. It has worked well. Either would be too big without the other, and putting them together, they just are right.

RURAL OUTPATIENT-BASED CLINICS

Outpatient-based clinics are working splendidly and I have some questions asking you to address the staffing shortfalls that may exist in these rural facilities. I know your problems are terrific. I would just hope that you would take this opportunity to look carefully at the current group of veterans and make sure that we do not let any of them fall between the cracks. We do not need anyone coming to the American people saying we have let any of them get denied when they should have been cared for. That will be a very big story and a big black mark. So currently they are getting a lot of good care, but I hope the word is out that you all better make sure you take care of them and take care of them well.

Thank you. Thank you very much, Mr. Chairman.

Senator BOND. Thank you very much, Senator Domenici, for your very appropriate comments.

And now, finally, we will get to the testimony of Secretary Principi. We thank you for your attention to our concerns, and we will make your full statement a part of the record and ask you to proceed.

STATEMENT OF ANTHONY J. PRINCIPI

Secretary PRINCIPI. Thank you, Mr. Chairman, Chairman Bond, Senator Mikulski, and members of the committee. I am pleased to have this opportunity to testify on our proposed budget for fiscal year 2005 to address some of the challenges that you raise. I too am constantly reminded that we live in a difficult time and young men and women are coming back to our shores, having served so magnificently in combat theaters of operation and even on the front lines in the ramparts of freedom, and we need to be there for them and we cannot afford to have anyone fall through the cracks. It is a very, very high priority. I feel very deeply about this.

I want to thank you both for your kind comments, but most importantly, I want to thank you for your extraordinary support for my Department and for the veterans of this Nation. I think the progress we have made in recent years is directly proportional to the tremendous support that you, Mr. Chairman, and Senator Mikulski have given to my Department.

The President proposed a VA budget for fiscal year 2005 that will, if it is approved, ensure that 800,000 more veterans receive medical care than VA cared for in 2001, the year I became Secretary of Veterans Affairs. As you indicated, our health care budget has grown dramatically in recent years and with the 2005 budget, the 4-year cumulative will be more than 40 percent. Again, on behalf of America's veterans I thank both the President and the members of this committee for your enormous contribution to this achievement. This 4-year cumulative total is probably the largest increase certainly in 50 years and perhaps in the history of the VA. My budget has gone from $48 billion overall to about $65 billion in 2004, and with this budget, it will go up well over $70 billion in 2005.

As a result of these budget increases and the tremendous hard work of the people at the table with me and those throughout the VA, quality of veterans' health care in my view has never been so good. This is not my dad's VA. Never before has access been this broad. We have almost 800 community-based outpatient clinics, and prior to the mid-1990's we had none. Never before have we treated so many veterans at so many locations. That is the good news.

The challenging news is that we have a lot of work ahead of us because more and more veterans are coming to us for health care. But I believe that with the 2005 budget and what you have provided to us in 2004, we will have the resources we need to meet our goal of scheduling non-urgent primary care appointments for 93 percent of the veterans within 30 days and 99 percent within 90 days.

In July of 2002, not really too long ago, we had 317,000 veterans who were waiting more than 6 months for an appointment. Today

that number is down to about 22,000, of which only about 5,000 are waiting for an initial visit. We will continue to focus on the medical needs of veterans identified by Congress as the highest priority, the service-connected disabled veterans, the poorest of the poor, the low income who have few if any other options for health care in this country, and those who need our specialized services like blind rehabilitation and spinal cord injury.

This budget request also more than doubles from the current fiscal year our appropriation request for construction of the new and improved facilities soon to be identified through our CARES process. And I look forward to the opportunity to talk with you about CARES during the question and answer period.

In addition, I plan to use the authority that you have given me to apply up to $400 million of the 2004 appropriation to CARES projects to modernize our infrastructure throughout the country. This makes a total of approximately $1 billion that we will be able to commit during 2004 and 2005 to transforming VA's medical facilities into a 21st century health care system and not one from the century gone by.

Perhaps most importantly the budget will fund high quality care for veterans returning to our shores from overseas conflicts. Approximately 19,600 of the 145,000 returnees from Iraq and Afghanistan have sought and been provided VA health care, and I know that number will increase in years to come.

The budget request also sustains our tremendous progress in bringing down the disability claims backlog. By the end of last fiscal year, we reduced our inventory of rating-related claims, claims for disability compensation and pension, from a high of 432,000 to 253,000. And the percentage of veterans waiting more than 6 months for a decision was down to 18 percent from 48 percent. A court of appeals decision in September 2003 made us hold claims where part of the decision was a denial for a year, and our backlog shot back up, but the Congress fixed that problem and we are now back on track to achieve my goal of 250,000 and about 100 days' processing time by the end of this year. We now decide more than 60,000 cases a month, up from about 40,000 per month in 2001. And that is because of the people you have given us and the hard work of our Veterans Benefits Administration folks.

The President's request will also continue the greatest expansion of the national cemetery system since the Civil War and fund long-deferred maintenance needed to ensure our cemeteries are recognized as national shrines. We will open up 11 new national cemeteries between now and the year 2009, which will increase our gravesite capacity by 85 percent. And that is needed because of the large number of World War II veterans and Korean veterans that are passing from us.

As you indicated, Senator Mikulski, the budget emphasizes our health care commitment to the poor. So we propose to raise the income threshold, exempting low income veterans from pharmacy co-payments, from an income of $9,800 a year to $16,500. Of course, we ask for elimination for all co-payments for former prisoners or war and those in end-of-life care and hospice care and palliative care. We also ask for the authority to reimburse veteran patients for their out-of-pocket costs in those cases where they must make

co-payments to their insurance companies for non-VA emergency care, when they seek emergency care in private hospitals and have to make co-payments.

The budget does propose an increase, as you indicated, for pharmacy co-payments to $15 for a 30-day supply and I believe a modest annual fee for higher income veterans, non-disabled veterans, using our system that really totals less than $21 a month, a very small portion of the cost of care and comparable to the amount military retirees, enlisted people who retire after 20 years of service, devote their career to the military, have to pay to enroll in the TRICARE prime program. So I think there is an equity issue and that is why I think the $250 was a reasonable amount for veterans with the higher incomes and no disabilities to pay. But I understand the reticence of the members of the committee.

PREPARED STATEMENT

I place a very high priority on effective and efficient management of the resources entrusted to the Department by Congress. By financial management initiatives and medical care collections, debt management procurement reform, we will continue to increase the resources that are made available to veterans because every dollar we waste is a dollar that we cannot spend on veterans' health care. The same is true with CARES. Every dollar we spend on utility bills for empty buildings is a dollar we do not have to spend on veteran's health care. And that is why I believe the CARES process is so important.

That concludes my testimony, Mr. Chairman, Senator Mikulski. I look forward to answering your questions.

[The statement follows:]

PREPARED STATEMENT OF ANTHONY J. PRINCIPI

Mr. Chairman and members of the committee, good afternoon. I am pleased to be here today to present the President's 2005 budget proposal for the Department of Veterans Affairs (VA). The focal point of this budget is our firm commitment to continue to bring balance back to our health care system by focusing on veterans in the highest statutory priority groups.

The President's 2005 budget request totals $67.7 billion (an increase of $5.6 billion in budget authority)—$35.6 billion for entitlement programs and $32.1 billion for discretionary programs. Our request for discretionary funds represents an increase of $1.2 billion, or 3.8 percent, over the enacted level for 2004, and supports my three highest priorities:

—provide timely, high-quality health care to our core constituency—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;

—improve the timeliness and accuracy of claims processing;

—ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines.

The growth in discretionary resources will support a broad array of benefits and services that VA provides to our Nation's veterans. Including medical care collections, funding for the medical care program rises by $1.17 billion over the 2004 enacted level. As a principal component of our medical care budget, we are requesting $524 million to begin implementing recommendations stemming from studies associated with the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our budget request using a slightly modified new budget account structure that we proposed for the first time last year. This new structure more clearly presents the full funding for each of the benefits and services we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program. I am committed to providing Congress with the information and tools it needs to be comfortable with enacting the change.

MEDICAL CARE

The President's 2005 request includes total budgetary resources of $29.5 billion (including $2.4 billion in collections) for the medical care program, an increase of 4.1 percent over the enacted level for 2004, and more than 40 percent above the 2001 level. With these resources, VA will be able to provide timely, high-quality health care to nearly 5.2 million unique patients, a total 21 percent higher than the number of patients we treated in 2001.

I have taken several steps during the last year to refocus VA's health care system on our highest priority veterans, particularly service-connected disabled veterans who are the very reason this Department exists. For example, we recently issued a directive that ensures veterans seeking care for service-connected medical problems will receive priority access to our health care system. This new directive provides that all veterans requiring care for a service-connected disability, regardless of the extent of the injury or illness, must be scheduled for a primary care evaluation within 30 days of their request for care. If a VA facility is unable to schedule an appointment within 30 days, it must arrange for care at another VA facility, at a contract facility, or through a sharing agreement.

By highlighting our emphasis on our core constituency (Priority Levels 1–6), we will increase our focus on the Congressionally-identified highest priority veterans. The number of patients within our core service population that we project will come to VA for health care in 2005 will be nearly 3.7 million, or 12 percent higher than in 2003. During 2005, 71 percent of those using VA's health care system will be veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs. The comparable share in 2003 was 66 percent. In addition, we devote 88 percent of our health care funding to meet the needs of these veterans.

While part of our strategy for ensuring timely, high-quality care for our highest priority veterans involves a request for additional resources, an equally important component of this approach includes a series of proposed regulatory and legislative changes that would require lower priority veterans to assume a small share of the cost of their health care. These legislative proposals are consistent with recent Medicare reform that addresses the difference in the ability to pay for health care. We are submitting these proposals for Congress' reconsideration because we strongly believe they represent the best opportunity for VA to secure the necessary budgetary resources to serve our core population. Among the most significant legislative changes presented in this budget are to:

—assess an annual use fee of $250 for Priority 7 and 8 veterans; and

—increase co-payments for pharmacy benefits for Priority 7 and 8 veterans from $7 to $15.

We will work with Congress to enact our legislative proposal to eliminate the pharmacy co-payment for Priority 2–5 veterans, who have fewer means by which to pay for these costs, by raising the income threshold from the pension level of $9,894 to the aid and attendance level of $16,509 (for a single veteran). This would allow about 394,000 veterans within our core constituency to receive outpatient medications without having to make a co-payment.

The 2005 budget includes several other legislative and regulatory proposals that are designed to expand health care benefits for the Nation's veterans. Among the most significant of these is a provision that would give the Department the authority to pay for insured veteran patients' out-of-pocket expenses for urgent care services if emergency/urgent care is obtained outside of the VA health care system. This proposal would ensure that veterans with life-threatening illnesses can seek and receive care at the closest possible medical facility. In addition, we are proposing to eliminate the co-payment requirement for all hospice care provided in a VA setting and all co-payments assessed to former prisoners of war. Currently, veterans are charged a co-payment if hospice care cannot be provided in a VA nursing home bed either because of clinical complexity or lack of availability of nursing home beds.

The President's 2005 budget for VA's medical care program also continues our effort to expand access to long-term care for veterans. This budget includes a legislative proposal to focus long-term care on non-institutional settings by expanding the 1998 average daily census nursing home capacity requirement to include the following categories of extended care services—nursing homes, community residential care programs, residential rehabilitation treatment programs, home care programs, non-institutional extended care services under VA's jurisdiction, and long-term care beds for which the Department pays a per diem to States for services in State homes. As part of this effort, we aim to significantly enhance access to non-institutional care programs that allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

In return for the resources we are requesting for the medical care program in 2005, we will continue to aggressively pursue my priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. During the last 3 years, we have significantly enhanced veterans' access to health care. We have opened 194 new community clinics, bringing the total to 676. Nearly 9 out of every 10 veterans now live within 30 minutes of a VA medical facility. This expanded level of access has resulted in an increase in the number of outpatient visits from 44 million in 2001 to 51 million in 2003, as well as a 26 percent rate of growth in the annual number of prescriptions filled to a total of 108 million last year. To further highlight the Department's emphasis on the delivery of timely, accessible health care, our standard of care for primary care is that 93 percent of appointments will be scheduled within 30 days of the desired date and 99 percent of all appointments will be scheduled within 90 days. For appointments with specialists, the comparable performance goal is 90 percent within 30 days of the desired date.

As I mentioned earlier Mr. Chairman, a key component of our overall access goals is the assurance that veterans seeking care for service-connected medical problems will receive priority access to health care. In addition, we have dramatically reduced the number of veterans on the waiting list for primary care.

VA's health care system continues to be characterized by a coordinated continuum of care and achievement of performance outcomes that improve services to veterans. In fact, VA has exceeded the performance of private sector and Medicare providers for all 18 key health care indicators, from diabetes care to cancer screening and immunizations. The Institute of Medicine has recognized the Department's integrated health care system, including our framework for using performance measures to improve quality, as one of the best in the Nation. Additionally, VA's quality score based on a survey conducted by the Joint Commission on Accreditation of Healthcare Organizations exceeds the national average quality score (93 versus 91).

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We expect to show improvements in both of our principal measures of health care quality. The clinical practice guidelines index will rise to 71 percent in 2005, while the prevention index will increase to 84 percent.

The 2005 budget includes additional management savings of $340 million that will partially offset the need for additional funds to handle the increasing utilization of health care resources, particularly among our highest priority veterans who require much more extensive care, on average, than lower priority veterans. We will achieve these management savings through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies such as consolidations.

Our projection of medical care collections for 2005 is $2.4 billion. This total is 38 percent above our estimated collections for 2004 and is more than three times the collections level from 2001. Approximately $407 million, or 61 percent, of the increase above 2004 is possible as a result of the proposed medical care policy initiatives. The Department continues to implement the series of aggressive steps identified in our revenue cycle improvement plan in order to maximize the health care resources available for the medical care program. We are establishing industry-based performance and operational metrics, developing technological enhancements, and integrating industry-proven business approaches, including the establishment of centralized revenue operation centers. For example, during the last year we have lowered the share of reimbursable claims receivable greater than 90 days old from 84 percent to 39 percent, and we have decreased the average time to produce a bill from 117 days to 49 days. Further, the Department is implementing the Patient Financial Services System in Veterans Integrated Service Network 10 (Ohio). This will be a single billing system that we will use for both hospital costs as well as physician costs, and involves comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DOD) to enhance the coordination of the delivery of benefits and service to veterans. To address this Presidential initiative, our two Departments established a high-level Joint Executive Council to develop and implement significant collaborative efforts. We are focusing on three major system-wide issues: (1) facilitating electronic sharing of enrollment and eligibility information for services and benefits; (2) establishing an electronic patient health record system that will allow rapid exchange of patient information between the two organizations by the end of 2005; and (3) increasing the number of shared medical care facilities and staff. The sharing of DOD enrollment and eligibility data will reduce the burden on veterans to provide duplicative information when making the transi-

tion to VA for care or benefits. Shared medical information is extremely important to ensure that veterans receive safe and proper care. VA and DOD are working together to share facilities and staff in order to provide needed services to all patients in the most efficient and effective manner.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The 2005 budget includes $524 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative, a figure more than double the amount requested for CARES for 2004. This is a multi-year program to update VA's infrastructure to meet the needs of veterans in the 21st century and to keep our Department on the cutting edge of medicine. CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access. The resources we are requesting for this program will be used to implement the various recommendations within the National CARES plan by funding advance planning, design development, and construction costs for capital initiatives.

Mr. Chairman, the independent commission that reviewed our draft CARES plan has delivered their report to me. I am in the process of reviewing the commission's analysis and recommendations. We will thoroughly evaluate their report and seriously consider their recommendations before making our final realignment decisions and preparing for the next phase of the CARES program.

MEDICAL AND PROSTHETIC RESEARCH

The President's 2005 budget includes total resources of $1.7 billion to support VA's medical and prosthetic research program. This request is comprised of $770 million in appropriated funds, $670 million in funding from other Federal agencies such as DOD and the National Institutes of Health, as well as $230 million from universities and other private institutions. Our budget includes an initiative to assess pharmaceutical companies for the indirect administrative costs associated with the clinical drug trials we conduct for these organizations.

This $1.7 billion will support nearly 2,900 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, aging, diabetes, heart disease, mental illness, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

VETERANS' BENEFITS

The Department's 2005 budget request includes $36 billion for the entitlement costs associated with all benefits administered by the Veterans Benefits Administration (VBA). Included in this total, is an additional $2.740 billion for disability compensation payments to veterans and their survivors for disabilities or diseases incurred or aggravated while on active duty. Recipients of these compensation benefits will have increased from 2.3 million in 2001 to over 2.6 million in 2005. The budget includes another $1.19 billion for the management of these programs—disability compensation; pensions; education; vocational rehabilitation and employment; housing; and life insurance. This is an increase of $26 million, or 2.2 percent, over the enacted level for 2004.

We have made excellent progress in addressing the Presidential priority of improving the timeliness and accuracy of claims processing. Not only have we hired and trained more than 1,800 new employees in the last 3 years to directly address our claims processing backlog, but the productivity of our staff has increased dramatically as well. Between 2001 and 2003, the average number of claims we completed per month grew by 70 percent, from 40,000 to 68,000. Last year the inventory of rating-related compensation and pension claims peaked at 432,000. By the end of 2003, we had reduced this backlog of pending claims to just over 250,000, a drop of over 40 percent. We have experienced an increase in the backlog during the last few months, due in large part to the impact of the court decision (PVA v Secretary of Veterans Affairs) that interpreted the Veterans Claims Assistance Act of 2000 as requiring VA to wait a full year before denying a claim. However, this rise in the number of pending claims will be temporary, and we expect the backlog to be back down to about the 250,000 level by the end of 2004. We thank the Congress for the legislation that eliminated the mandatory 1-year waiting period.

In 2002 it took an average of 223 days to process a claim. Today, it takes about 150 days. We are on track to reach an average processing time of 100 days by the end of 2004 and expect to maintain this timeliness standard in 2005. One of the main reasons we will be able to meet and then sustain this improved timeliness

level is that we have reduced the proportion of claims pending over 6 months from 48 percent to just 19 percent during the last 3 years.

To assist in achieving this ambitious goal, VA established benefits delivery at discharge programs at 136 military installations around the country. This initiative makes it more convenient for separating servicemembers to apply for and receive the benefits they have earned, and helps ensure claims are processed more rapidly. Also, the Department has assigned VA rating specialists and physicians to military bases where servicemembers can have their claims processed before they leave active duty military service.

We expect to see an increase in claims resulting from the return of our brave servicemen and women who fought to protect the principles of freedom in Operation Enduring Freedom and Operation Iraqi Freedom. We propose to use $72 million of the funds available from the war supplemental during 2004 to address the challenges resulting from an increasing claims processing workload in order to assist us in reaching our timeliness goal of 100 days by the end of 2004. We propose to use the remaining $28 million in 2005 to help sustain this timeliness standard.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2005 performance goal for the national accuracy rate for compensation claims is 88 percent, well above the 2001 accuracy level of 80 percent.

This budget request includes additional staff and resources for new and ongoing information technology projects to support improved claims processing. We are requesting $2 million for the Virtual VA project, the ultimate goal of which is to replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. The 2005 funding will maintain Virtual VA at the three Pension Maintenance Centers. We are seeking $3.4 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process. In addition, we are requesting $2.6 million in 2005 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

The Veterans Service Network (VETSNET) development is nearing completion and is scheduled to begin deployment in April 2004. This system offers numerous improvements over the legacy Benefits Delivery Network (BDN) that it is replacing (e.g., correction of material weaknesses and implementation of comprehensive claims processing within a modern corporate environment). Sufficient platform capacity is required to successfully deploy VETSNET and to ensure the continued and uninterrupted payment of approximately $24 billion annually in benefits to around 3.4 million deserving veterans and their beneficiaries. Therefore, $5 million in funding is requested to procure the capacity required. This platform capacity will ensure successful deployment and operation of VETSNET throughout VBA's Regional Offices and in a modern corporate environment that integrates all components of claims processing (e.g., establishing the claim, rating the claim, preparing the claim award, and paying the claim award). Without sufficient platform capacity, the Veterans Benefits Administration will be unable to operate this critical new system.

In support of the education program, the budget proposes $5.2 million for continuing the development of the Education Expert System. These resources will be used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment certification. This initiative will contribute toward achievement of our 2005 performance goals for the average time it takes to process claims for original and supplemental education benefits of 25 days and 13 days, respectively.

VA is requesting $9.6 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will allow us to answer calls at any place and at any time without complex call routing devices.

In order to make the delivery of VA benefits and services more convenient for veterans and more efficient for the Department, we are requesting $1.5 million for the collocation and relocation of some regional offices. Some of this will involve housing regional office operations in existing VA medical facilities. In addition, we are examining the possibility of collocations using enhanced-use authority, which entails an agreement with a private developer to construct a facility on Department-owned grounds and then leasing all or part of it back to VA. At the end of these long-term lease agreements, the land and all improvements revert to VA ownership.

BURIAL

The President's 2005 budget includes $455 million for the burial program, of which $181 million is for mandatory funding for VA burial benefits and payments and $274 million is for discretionary funding, including operating and capital costs for the National Cemetery Administration and the State Cemetery Grant program. The increase in discretionary funding is $9 million, or 3.4 percent, over the enacted level for 2004, and includes operating funds for the five new cemeteries opening in 2005.

This budget request includes $926,000 to complete the activation of new national cemeteries in the areas of Detroit, MI and Sacramento, CA. These are the last two of the six locations identified in the May 2000 report to Congress as the areas most in need of a national cemetery. The other four cemeteries will serve veterans in the areas of Atlanta, GA, South Florida, Pittsburgh, PA, and Fort Sill, OK.

With the opening of new national cemeteries and State veterans cemeteries, the percentage of veterans served by a burial option within 75 miles of their residence will rise to 83 percent in 2005. The comparable share was less than 73 percent in 2001.

The $81 million in construction funding for the burial program in 2005 includes resources for Phase 1 development of the Sacramento National Cemetery (CA) as well as expansion and improvements at the Florida National Cemetery (Bushnell, FL) and Rock Island National Cemetery (IL). The request includes advanced planning funds for site selection and preliminary activities for six new national cemeteries to serve veterans in the following areas—Bakersfield, CA; Birmingham, AL; Columbia/Greenville, SC; Jacksonville, FL; Sarasota County, FL; and southeastern Pennsylvania. Completion of these new cemeteries will represent an 85 percent expansion of the number of gravesites available in the national cemetery system since 2001, almost doubling the number of gravesites during this time period. In addition, the budget includes $32 million for the State Cemetery Grant program.

In return for the resources we are requesting for the burial program, we expect to achieve extremely high levels of performance in 2005 and to continue our noble work to maintain the appearance of national cemeteries as shrines dedicated to honoring the service and sacrifice of veterans. Our performance goal for the percent of survey respondents who rate the quality of service provided by the national cemeteries as excellent is 96 percent, and our goal for the percent of survey respondents who rate national cemetery appearance as excellent is 98 percent. In addition, we will continue to place emphasis on the timeliness of marking graves. Our performance goal for the percent of graves in national cemeteries marked within 60 days of interment is 82 percent in 2005, a figure dramatically above the 2002 performance level of 49 percent.

MANAGEMENT IMPROVEMENTS

Mr. Chairman, we have made excellent progress during the last year in implementing the President's Management Agenda. Our progress in the financial, electronic government, budget and performance, and DOD/VA coordination areas is currently rated "green." Our human capital score is "yellow" due only to some very short-term delays. However, VA's competitive sourcing rating is "red" because existing legislation precludes us from using necessary resources to conduct cost comparisons of competing jobs such as laundry, food and sanitation service. The administration will work with Congress to develop legislation to advance this effort that would free up additional resources to be used to provide direct medical services to veterans. We will continue to take the steps necessary to achieve the ultimate goals the President established for each of the focus areas.

We have several management improvement initiatives underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes. We are currently realigning our finance, acquisition, and capital asset management functions into business offices across the Department. There will be one business office in each of the 21 Veterans Integrated Service Networks and a single office for the National Cemetery Administration. For the Veterans Benefits Administration, the majority of the field functions will be centralized into product lines. In addition, we are establishing an Office of Business Oversight in our Office of Management that will provide much stronger oversight of these functions by our Chief Financial Officer, will improve operations through more specialization, and will achieve efficiencies in staffing. The realignment of these business functions will reduce and standardize field business activities into a more manageable size, limit the number of sites to be reviewed, provide for more consistent interpretation of policies and procedures, and promote implementation of performance metrics and data collection related to these business functions. As a re-

sult of the realignment, we will significantly strengthen compliance and consistency with finance, acquisition, and capital asset policies and procedures.

We continue to make excellent progress in implementing the recommendations of our Procurement Reform Task Force, as 43 of the 65 recommendations have been completed. By the end of 2004, we expect to implement all of the remaining recommendations. These procurement reforms will optimize the performance of VA's acquisition system and processes by improving efficiency and accountability. We expect to realize savings of about $250 million by the end of 2004 as a result of these improvement initiatives. This figure will rise after we have completed all 65 recommendations.

During 2005 VA will continue developing our enterprise architecture that will ensure that all new information technology (IT) projects are aligned with the President's E-government initiatives as well as the Department's strategic objectives. The enterprise architecture will help eliminate redundant systems throughout VA, improve IT accountability and cost containment, leverage secure and technologically sound solutions that have been implemented, and ensure that our IT assets are built upon widely accepted industry standards and best practices in order to improve delivery of benefits and services to veterans. One of our primary focus areas in IT will be cyber security. We will concentrate on securing the enterprise architecture and providing continuous protection to all VA systems and networks. This will require purchases of both hardware and software to address existing vulnerabilities.

We are continuing the development and implementation of our CoreFLS project to replace VA's existing core financial management and logistics systems with an integrated, commercial off-the-shelf package. CoreFLS will help us address and correct management and financial weaknesses in the areas of effective integration of financial transactions from Department systems, necessary financial support for credit reform initiatives, and improved automated analytical and reconciliation tools. We have conducted initial tests at selected sites and are still on schedule for full implementation during 2006.

The Department has developed a comprehensive human capital management plan and has started implementing some of the strategies outlined in this plan. In addition, we are implementing a redesigned performance appraisal system to better ensure that all employees' performance plans are linked with VA's mission, goals, and objectives.

CLOSING

Mr. Chairman, VA has achieved numerous successes during the last 3 years that have significantly improved service to our country's veterans. We have enhanced veterans' access to our health care services that set the national standard with regard to quality; improved the timeliness of health care delivery; expanded programs for veterans with special health care needs; dramatically lowered the time it takes to process veterans' claims for benefits; and expanded access to our national cemetery system. The President's 2005 budget will provide VA with the resources necessary to continue to improve our delivery of benefits and services, particularly for veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

MEDICAL CARE FUNDING

Senator BOND. Thank you very much, Mr. Secretary.

I understand you recently sent a letter to House Budget Committee Chairman Nussle endorsing an additional $1.2 billion over the budget request for VA medical care, making the safe assumption that the administration's proposed fees will not be accepted by the Congress. Will $1.2 billion be adequate to ensure that the VA will be able to meet its medical care needs for 2005?

Secretary PRINCIPI. Yes, it certainly will, Mr. Chairman. I am very pleased I was given the authority to endorse the budget resolution, adding $1.2 billion to our appropriation because of the understanding that Congress would not enact the policy reforms on user fees and co-payments. Therefore, those dollars would be necessary to ensure that our waiting lists and waiting times for ap-

pointments do not go up. It will also allow us to slightly increase staffing in our Benefits Administration, increase the amount for research and a little bit for CARES as well. So the $1.2 billion would, indeed, allow us to continue to stay on track.

CARES

Senator BOND. Speaking of CARES, I understand you had some personal experiences where you have seen veterans' hospitals apparently with some unneeded space, maybe in Chicago and something about New York. You said rather than spending the money on unneeded electricity, what do you mean by that, Mr. Secretary?

Secretary PRINCIPI. Well, I had an interesting evening one night. I was in New York City driving up 1st Avenue to an event up in midtown, and I was caught in traffic at the corner of 23rd and 1st Avenue and looking up the VA medical center, an 18-story bed tower at about 7:30 at night and I noticed no lights on or virtually no lights on. I knew there was power because some lights were on.

I went back to my office the next day and I asked for the information on the New York City medical centers, Brooklyn, Manhattan, and Bronx, and how large are these medical centers and how many patients do we have in them because I did not see any lights on in the bed tower. They came back and said the Bronx was built to 1,800 beds in 1920, downsized to about 850 beds in the 1970's. Manhattan was built to 1,000 beds in 1950 and Brooklyn was built to 1,300 beds in 1950 as well. And the day I was in New York, they had a combined inpatient census of 385 patients. So we have three medical centers within relatively short distance of one another that were built to 3,000 beds. Of course, they had been converted to other uses, and there were only 385 patients in them.

I think that is an indication that medical care has changed so dramatically in this country going to outpatient care and ambulatory surgery and reducing lengths of stay and drug therapy and using technology, telehealth, that we were spending an awful lot of money on maintenance of very old buildings that are no longer defined as health care delivery. And veterans deserve better than that.

That is why I believe this process is so important to ensure that we have a modern infrastructure with medical centers, tertiary care hospitals that are supported by multi-specialty outpatient clinics and that are supported by primary care clinics. That was the example I used.

Senator BOND. In addition to the obvious benefits of CARES, I believe it will also spur some major construction spending. There are some estimates that VA would spend some $4 billion to $6 billion in new construction under CARES. For 2004, how much money will VA be able to spend on new construction projects under CARES and how many do you think could be funded immediately? How would you prioritize the funding?

Secretary PRINCIPI. Mr. Chairman, CARES is not about saving money. CARES is about modernization. The VA health care infrastructure is aging and we have not made the investment in it for many years that we should. So I think the budget estimates in the area that you mentioned, $5 billion to $7 billion, over a period of years is approximately correct. We have almost $1 billion in 2004

and 2005 that would be available to begin the process. Much of it will be advance planning and design funding in 2004 that would allow us in 2005 to award contracts to begin to modernize.

Senator BOND. I will now defer to my colleague from Maryland to continue the questioning. Thank you.

Senator MIKULSKI. Thank you, Mr. Chairman.

ENROLLMENT FEE AND COPAYMENTS

Mr. Secretary, I want to raise the issue once again about something that Congress rejected last year, which is the issue of charging category 7 and 8 veterans, those who do not have literally a service-connected disability, a $250 enrollment fee as well as more than doubling their drug co-payments from $7 to $15 and also outpatient co-payments by another $5. Some people call this $250 a user fee. I call it a toll charge to get into VA, which of course I object to.

Could you tell us why you picked $250? How many veterans will not enroll because of this fee? Was this done as a deterrent for veterans coming in? What is the point of the $250?

Secretary PRINCIPI. Well, I think the focus is to make sure that we first and foremost care for those high priority groups established by Congress, the service-connected disabled, the very poor, and those in need of specialized services and to ask those who can most afford to make a small contribution, if you will, to the cost of their care.

Why $250? Again, I am an E–6. I mean, I am a staff sergeant and I am in uniform for 20 years or 30 years and I have been overseas on combat tours. And I retire with maybe an income of $1,000 a month, $12,000 a year retirement after 20 years of military service. I have to enroll in TRICARE Prime to get medical care for myself and my family. I have to pay a minimum of $250-some-odd. So why is it fair that we mandate in this country that military retirees who have 20 years' service pay $250 to be enrolled in the TRICARE Prime program, but it is unfair to ask a veteran who maybe only served 2 years or 4 years in the military and has no disabilities to pay the same amount. So that is how I came up with the $250.

Senator MIKULSKI. Well, Mr. Secretary, I appreciate that. As you know, I feel and I think in your heart you feel that people paid their dues. They paid their dues in active duty. By the very nature of active duty, they might not have the kind of permanent wound of an orthopedic injury, spinal cord, or amputation. But you do not come home from war without consequences.

And I agree with your commentary about the TRICARE men and women. But you see, my response to that is why charge them $250 as well.

Secretary PRINCIPI. Of course, that is Department of Defense.

Senator MIKULSKI. I know that, but I want you to know that you are seeking parity with them because of essentially what you see is a fairness issue. I see as a fairness issue that when you serve in the military and if you have put in 20 years—while the rest of us are eating turkey on Thanksgiving, they are chasing some turkey down some hole somewhere. So I believe we have got to stand by our military.

But I understand your situation. You understand where we are coming from, but I just do not think you have to pay dues to get veterans health care.

But let me take an issue which we do know is exploding whether it is in the civilian population, the veterans' population, or in TRICARE: the cost of prescription drugs. We know many are turning to VA medical care because you offer a prescription drug benefit. Could you tell the committee how you are controlling the cost of drug purchases and at the same time not shackling the physician to prescribe what is medically necessary or medically appropriate? This is a challenge that we are facing and we would like to know, one, how are you doing it and, second, would there be lessons learned in other Government initiated programs?

PHARMACY BENEFIT MANAGEMENT PROGRAM

Secretary PRINCIPI. We have a model program in my view and one that has been very, very successful because it is a pharmacy benefit management program that brings clinicians and administrators and pharmacists together to make decisions on our program.

How do we do it? We have a national formulary. Of course, physicians, if they need to order a drug off the formulary, they can do so, but we try to stick to the formulary.

Senator MIKULSKI. And that would be because of evidence-based medical necessity.

Secretary PRINCIPI. Exactly. Sixty-five percent of the drugs we prescribe are generic. So we try to use generic drugs whenever therapeutically equivalent. And we buy in large sums. We leverage our purchasing power and use consolidated mail-out pharmacies.

The results of all of this have been that we have been able to keep our prescription drug costs to manufacturers' level just over the past 4 years. The only inflation comes from the large number of veterans who are coming to us. But the actual cost for ingredients has been steady at around $15 for a 30-day supply of drugs. And that is pretty extraordinary in my view. It comes about from a formulary, generic drugs, and national procurement.

Senator MIKULSKI. So you have a pharmacy benefit management. Second, you use generic drugs. You also use mail-out pharmacies so that, for example, for a diabetic, you do not have to continually have to go to get your testing supplies and some of those things that are——

Secretary PRINCIPI. It is mailed to you. Exactly. It is mailed from one of six or seven consolidated mail-out pharmacies.

Senator MIKULSKI. What you take is predictable. Then, of course, where there might be an infection or something, it requires timely treatment.

Now, let us go to the bulk purchasing. Essentially when I go to the Price Club or Sam's Club, it is discount because of bulk. You have got an Uncle Sam's Club. Right? You have got an Uncle Sam's Club with your bulk purchasing because essentially you are talking about managing primarily chronic illness which has a predictability, not the infections and so on.

Could you share with the committee how much you save in the bulk purchasing?

Secretary PRINCIPI. Well, I just have five drug classes here. I probably cannot even pronounce the names. Maybe I should let Dr. Perlin do so to give you an idea of the magnitude of the cost avoidance by buying in these large quantities for five drugs.

Dr. PERLIN. Senator, it is really quite remarkable. One is an acid reflux ulcer drug omeprazole. The savings by partnering and buying in bulk are $134 million to VA this year alone. Metformin is a drug for diabetes. The savings for that are $45 million this year alone. Terazosin, diltiazem, and felodipine all for blood pressure, and the savings for each of those are $44 million for terazosin, $23 million for diltiazem, and felodipine, $22 million. And that is just our top five.

Secretary PRINCIPI. Our 6-year savings in pharmaceuticals, as a result of the pharmacy benefit management program, have exceeded $1.1 billion. So we need to replicate that now in surgical, medical supplies, and equipment. There is an awful lot of money we are leaving on the table. We need to do more standardization, more national contracting for high-tech equipment like MRI's, as well as stents and bandages and surgical gloves. There is an awful lot of money that we can save the taxpayer and use for more medical care in the future.

Senator MIKULSKI. Well, we are all for this Uncle Sam's Club. I know my time is up, but what is interesting to me is for all the calls we get from veterans' families saying, "My father needs a nursing home, there is a waiting line for certain specialty care," et cetera, "nobody has called me and said I am not getting the drug that I need or the VA would not give me the drug. I went to another primary care doctor and got X." So it must be working. I think that, first of all, these are very informative. I would like to have more of a documentation on the savings. I think that these are lessons to be learned, and we want to follow up on that.

And then I will be talking about your demonstration issue in a minute.

Thank you, Mr. Chairman.

[The information follows:]

PRESCRIPTION DRUGS BULK PURCHASING

Question. Provide documentation on the savings of bulk purchasing of prescription drugs.

Answer.

Fiscal Year 1996	$1,900,000
Fiscal Year 1997	32,800,000
Fiscal Year 1998	88,600,000
Fiscal Year 1999	127,800,000
Fiscal Year 2000	186,800,000
Fiscal Year 2001	278,800,000
Fiscal Year 2002	444,400,000
Fiscal Year 2003	394,200,000
Fiscal Year 2004 (1st Qtr)	83,300,000
TOTAL	1,638,241,300

While standardization contracting is an important cost avoidance tool, VA uses other tools to reduce the expense of drug therapy, including: (1) purchasing drugs through a Pharmaceutical Prime Vendor using negative distribution fees; (2) purchasing drugs in bulk quantities not available in the commercial supply chain and repackaging those drugs in unit of use quantities; and, (3) managing the appropriate

utilization of drugs through the development and dissemination of evidence-based drug utilization guidelines. These strategies work together to help contain the growth of VA's pharmaceutical expenditures.

CARES

Senator BOND. Thank you, Senator Mikulski.

I would like to go back to the CARES discussion and ask you about Chicago. I would like an update on how progress on CARES is going in VISN 12, hear how the program is operating where one of the hospitals was scheduled to close and how it is affecting medical care. Has the closure of Lakeside had any adverse impact on the services for veterans and has the medical care service in VISN 12 improved?

Secretary PRINCIPI. I think this has become a success story. It was the first pilot that we started on CARES, and since the CARES decision was made, we have allocated $100 million to Chicago. Seventy-two million dollars is obligated, with the rest in minor projects. All of the Lakeside inpatients have been moved over to Westside which is in the poorer part of Chicago. We are in design at the present time for a new bed tower, a 200-bed bed tower. The intensive care unit has been completed. We have got a brand new, modern, state-of-the-art ICU. We have, through the enhanced use leasing, a new regional office and parking garage on the grounds of the VA medical center at Westside. At Hines, the new spinal cord injury and blind rehabilitation center, which is state-of-the-art, nothing like it in the country, is under construction and should be completed by the end of 2004. So I think this is an example of what could be done, how we can modernize a health care system and provide state-of-the-art, 21st century health care to 21st century veterans.

Senator BOND. I thank you for that. That is good news.

TRANSITIONAL PHARMACY BENEFIT PLAN

Let me turn to the transitional pharmacy benefit plan. I commend you for implementing the pilot program. We estimated originally that over 200,000 veterans would be eligible, but it now appears only 41,000 are eligible. I would like to know how it has reduced the waiting list. Why has the number changed so drastically? What is your current cost estimate of the program and how much does it save?

Secretary PRINCIPI. I will turn this over to Dr. Perlin. Let me just start out by saying about a third of the veterans who come to us, some places much higher, are only coming for prescription drugs. They may be enrolled in Medicare and have seen a doctor but they cannot get prescription drugs, so they are coming to us.

When we had those long waiting lists, I wanted to do a pilot project to see how well we could reduce the waiting times and provide the veterans with what they needed, prescription drugs. The pilot was generally successful although I think the data still needs to be analyzed. I know the Inspector General is looking into this and will have a report available shortly on the success of this pilot project. Perhaps Dr. Perlin can just give us some specifics.

Dr. PERLIN. Thank you, Mr. Chairman. The inception of the project occurred when we had huge waiting lists. As the Secretary

mentioned, a year and a half ago we had 176,000 patients waiting for their first appointment over 30 days. Since the time when it was implemented, I am pleased to say that the waiting list has diminished. That meant that the number of veterans who were waiting over 30 days came down to 42,000.

Of this 42,000, sir, 8,000 took part in the pharmacy benefit which was, in fairness, lower than we expected. We believe that some veterans may not have heard about the pharmacy benefit. We also believe that some may have found the process complex. It was a new process for us, a learning process in terms of processing prescriptions from outside of the system.

Because we have tighter control within our system with electronic prescribing and the closed formulary, we had some implementation challenges with prescriptions that were outside of our formulary. So all told, about 20 percent of those people used the program who were eligible and it was substantially lower than we initially had considered.

Senator BOND. I would like to ask Mr. Griffin if he has any additional views, the Inspector General. Have you come to any conclusions? Is there anything additional that you could provide on the program at this point? And if you would state your name for the record.

Mr. GRIFFIN. My name is Richard Griffin. I am the Inspector General for the Department of Veterans Affairs.

Senator BOND. Welcome.

Mr. GRIFFIN. As indicated by the Secretary, we have done some work in this area. We have recently finished a draft report which will be going to VHA for comments.

I would say that, in general, there were a number of issues that impacted the ability to have this program successfully kicked off. I would go back a few months prior to the start of the program to another audit which we had done at the Secretary's request on waiting times throughout the system. At that time, the reported waiting times in VHA were 309,000. Through the course of our audit, we determined that the actual number in May of 2003 was really 218,000, and that was as a result of some double-counting of some individuals. There were some other veterans who had enrolled in the system just so they would be enrolled but who were not actively seeking appointments from the Department. And there were some that were canceled or changed administratively but the record-keeping did not reflect that activity. So that is what was discovered in May.

One of our recommendations to VHA was that they continue to pursue electronic waiting times, which they have been doing and have been making good progress on. But that is just a few short months before the July date when the temporary pharmacy benefit was going to start, and some of those growing pains with the electronic process still existed. So as a result, the data that was being utilized to try and track how many veterans benefited from this program was not always accurate.

The other truth is that as a result of increases in staffing from previous budget years, a tremendous dent was made in those waiting lists in the 12 months preceding the kickoff of this benefit program.

So you had a combination of increased staffing being brought to bear against the workload. You had some facilities that accepted the challenge and put in the overtime and got the numbers down, and then we had a continued problem with the software and with the administration of the program.

Senator BOND. Thank you very much, Mr. Griffin. We will look forward to seeing your full report when it is ready.

Now I turn to Senator Leahy who has joined us. Thank you, Senator.

STATEMENT OF SENATOR PATRICK J. LEAHY

Senator LEAHY. Thank you, Mr. Chairman. I look around here. I wonder who is back running the store. Secretary Principi you have got everybody here. I know the buck stops here and I appreciate that. It is good to see you.

I really get worried—and I have told you this before—on the Veterans Affairs budget. We seem to go around and around. Last year we went back and forth to add $1.6 billion to the administration's budget request for fiscal year 2004, the current year. A month before the administration submitted its fiscal year 2005 budget, I joined several members of this subcommittee and the Veterans Committee to end the pattern of the administration where they come in with an unreasonably low request. They know that it is a request that nobody is going to accept, hoping that then Congress will find the money somewhere to bring it up, and it leaves a lower funding baseline the next year.

And the same thing happened again this year. The administration submitted a budget clearly short by several hundreds of millions of dollars. Veterans groups, everybody else has said it is short. They point to inflation. They point to increased costs of hospitalization, especially with so many coming back from Iraq and Afghanistan.

I do not know why we are in this. It has been reported that you asked for an additional $1 billion and you were turned down. I appreciate your asking for it. But what do you have to do? Even in an election year, you would think that somebody would listen to what veterans are saying. It is somewhat of a rhetorical question, but I would be delighted to hear an answer.

Secretary PRINCIPI. No. I appreciate the question.

Again, I would say I guess we always want more.

Senator LEAHY. No, no. Mr. Principi, it is not that we want more, it is we need more. And with the number of people coming back from Iraq and Afghanistan and everything else, we need more.

Secretary PRINCIPI. Well, men and women coming back from Iraq and Afghanistan have the highest priority in my view, and we will be there for them. We have to be there for them. We have no choice.

But again, my budget just in health care over this 4-year period has increased, if you include the 2005 budget as requested and if it becomes enacted, over 40 percent. Twenty-seven percent of that increase is from the President's request; 13 percent from congressional add-ons. So the problem is we, our government, opened the doors in 1998 to 25 million veterans. Prior to 1998 only 3 million had eligibility for the full continuum of VA health care. So we went

one day from 3 million to 25 million, and as the chairman said, we have this perfect storm. We have eligibility for all 25 million. No one is entitled but everyone is eligible. We have the best prescription drug program in the Nation. We have opened up now some 760 outpatient clinics that did not exist prior to 1995, and the quality of care is much better than for my dad. So we have this tremendous demand for health care, although our budget has risen rather dramatically.

MEDICAL RESEARCH

Senator LEAHY. Mr. Secretary, in your budget is a summary on page 1 to 6, take, for example, medical research spending. It says it is increased, but you are asking for a direct appropriation for medical and prosthetic research of $769 million. That is a $50 million cut. So, on the one hand, we are increasing all this, but then when you go to the fine print, it is saying it is cut.

MENTAL HEALTH

Now, you said that people coming back is the first priority, and I am sure you mean that and that is the way it should be. But I look at this article—and I am sure you read it—that was in the New York Times magazine on the incidence of post-traumatic stress disorder, depression among many of our troops returning from Iraq and Afghanistan. It says in this particular article a wounded veteran who is photographed here—you can see that he has lost an arm. Many are going through the medical evaluation board process. They get medical discharges. They become eligible to access care through the VA. But then we find that notwithstanding this huge increase, because of Iraq and Afghanistan, the mental health programs seem to be kind of an ugly stepchild of the VA. Notable shortages in psychiatric care for veterans in my own home State of Vermont which has a good VA hospital. We have the National Center for Post-traumatic Stress Disorder at the White River Junction VA Medical Center. They provide care and advice to the Army. They are going to continue doing that, but they have been flat-lined for the past few years, notwithstanding the increase in need.

You have so much support up here. I do not know how all this comes about. I mean, the administration can do all the great photo ops, and some of them are very valid. But a lot of them are not because we hear then from the veterans saying, oh, great, we got this increase. It is not really the way the budget came up. What are we going to do?

Secretary PRINCIPI. Well, again, Senator Leahy, when I started this business 3½ years ago, my budget was $48 billion. Today it is $65 billion.

Senator LEAHY. A lot of that was pushed in by the Congress.

Secretary PRINCIPI. But it has grown dramatically. We have treated 800,000 more veterans than the year before I became Secretary. I am not taking credit for that. I am just saying that 800,000 new veterans have come to the VA and received health care that did not in 2001. That is an extraordinary increase. And yes, more and more veterans are coming to the VA for lots of different reasons.

Mental health. You are right. Sometimes it does not get the allocation that I think it deserves. It is not as glamorous, if you will, as high-tech medicine, and we have to continually stress the importance of mental health programs.

Senator LEAHY. Will it get the allocation?

Secretary PRINCIPI. Sir?

Senator LEAHY. Will you give it the allocation?

Secretary PRINCIPI. Yes, I will give it the allocation. I convened a task force on mental health. They made some excellent recommendations to ensure that we have a baseline of spending across our entire system. Right now it is too un-uniform and inconsistent across the Nation.

In research, the appropriation piece has dropped by $50 million in this request, but the appropriation is one small part of our research program of $1.7 billion. From 2000 to 2003, we have gone from $504 million in grants from NIH and DOD to $704 million. So we are increasing the amount of money that is coming to the VA from other sources, NIH and Defense and pharmaceutical companies. So we will continue to work to ensure that our research program is robust.

Senator BOND. Thank you very much, Senator Leahy.

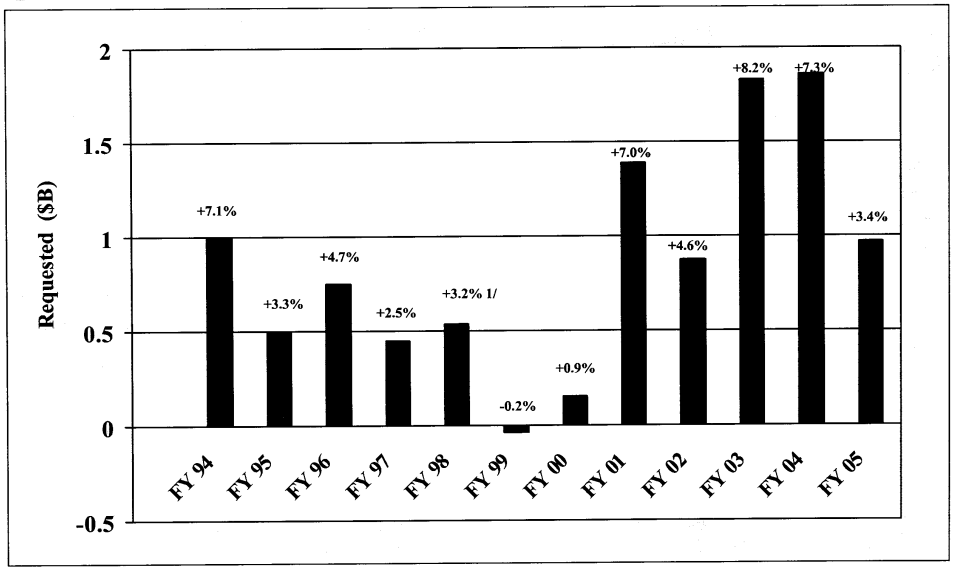
Senator LEAHY. Mr. Chairman, I will submit some other questions for the record.

Senator BOND. Thank you, sir. We will do that.

I think there is a medical care chart request that we will put in the record too, going back to the presidential requests for about the last 10 years, showing the percentage increase in requests. I have that here and we will make this available in the record.

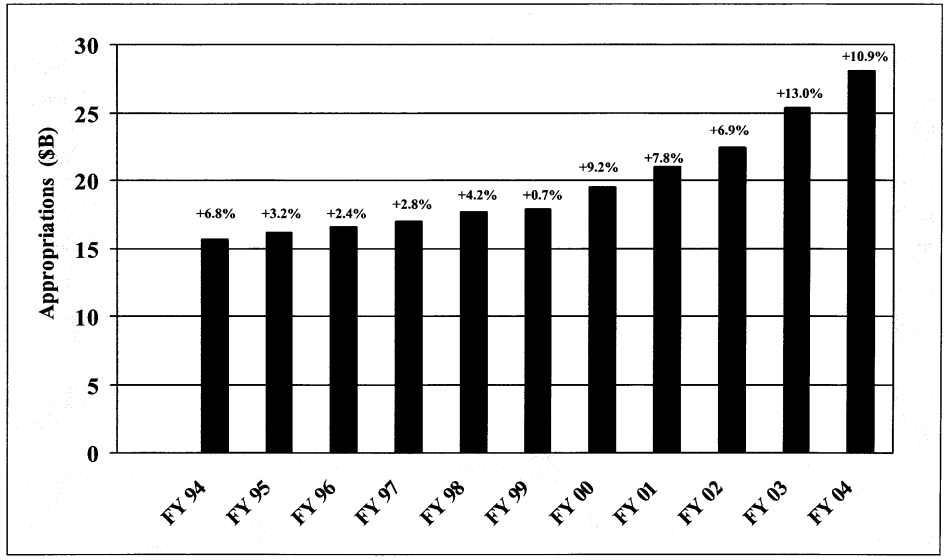
[The information follows:]

Medical Care Request Change Over Prior Year



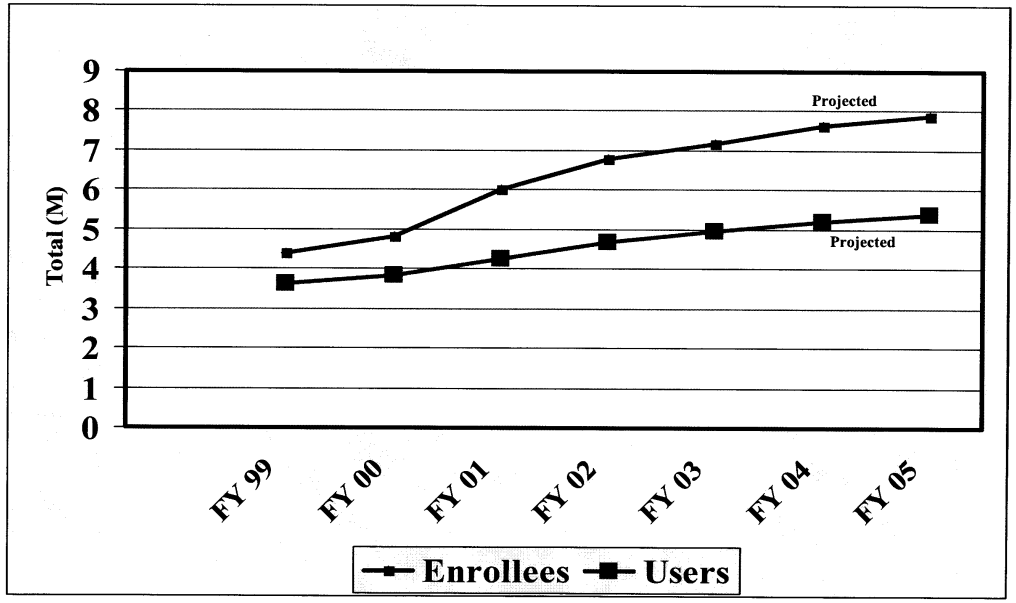
1/ Starting in 1998, open enrollment began and collections were made available to VA

Medical Care
Enacted Appropriations
Includes Collections

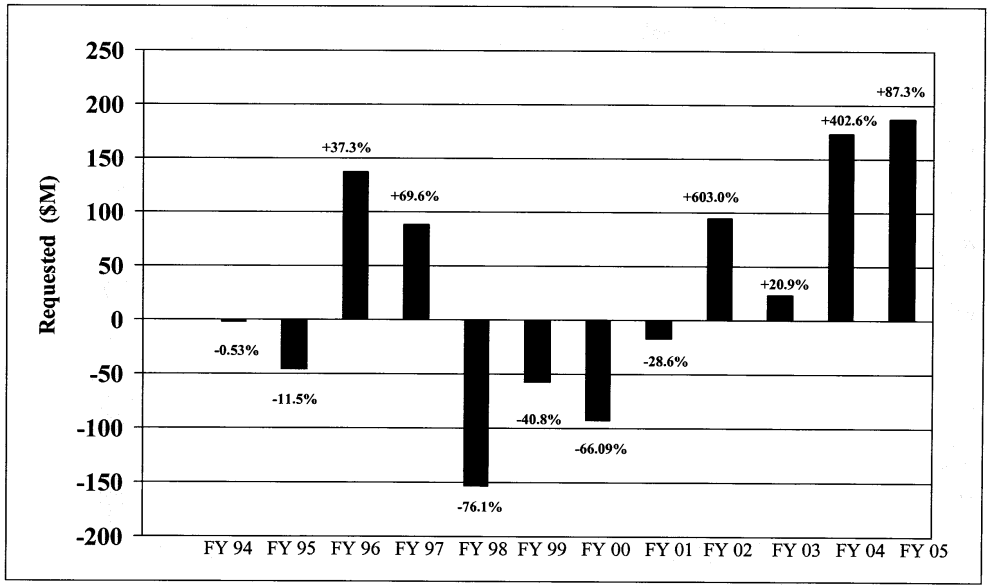


Percent change from prior year enacted levels. Starting in 1998, collections are available for VA

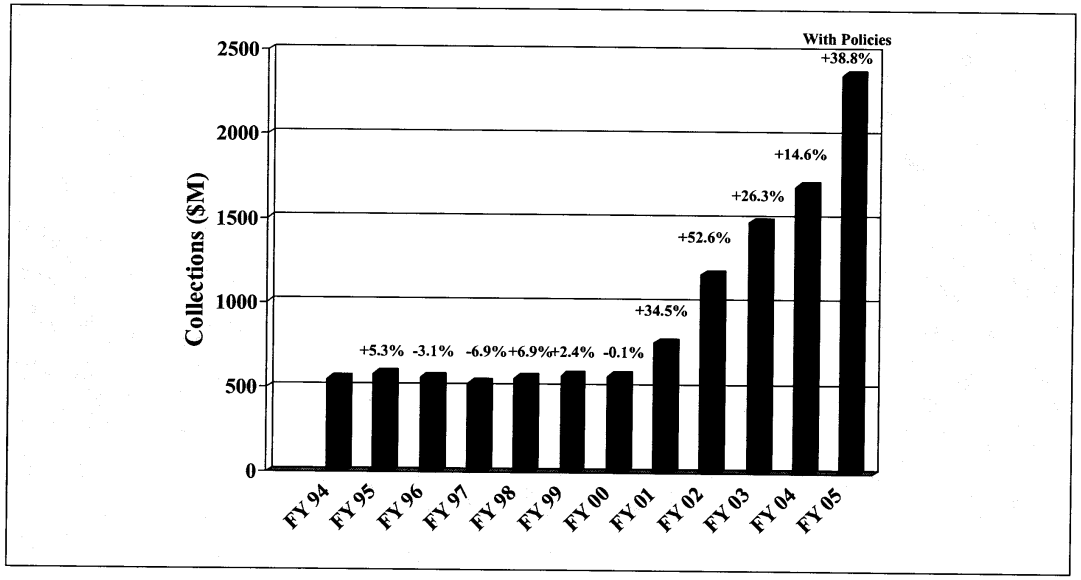
Health Care Workload



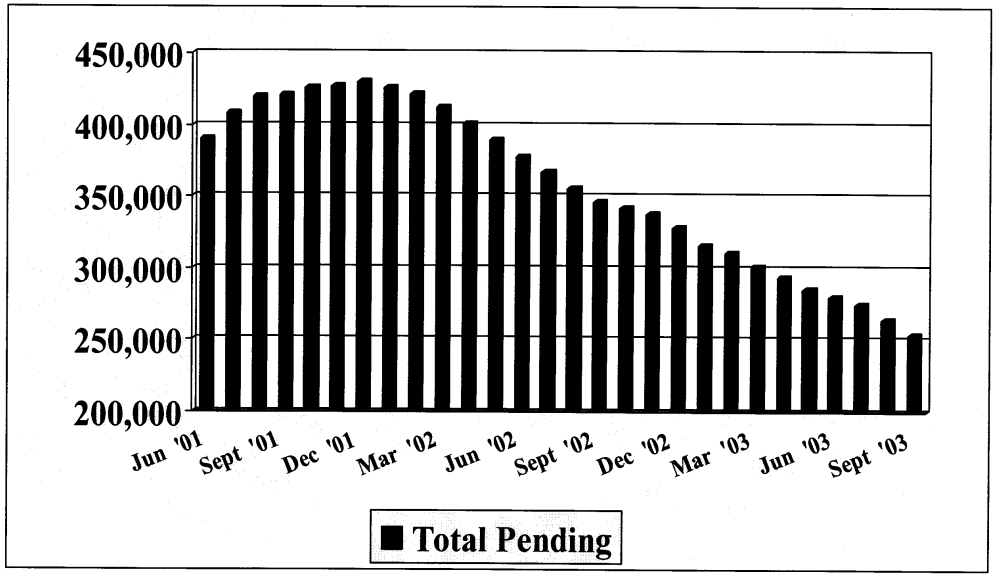
VHA Major Projects Request Change Over Prior Year



Medical Care Collection Fund



Status of Disability Claims Inventory



Senator BOND. Senator Mikulski, do you have some questions?

Senator MIKULSKI. Thank you very much, Mr. Chairman. I believe Secretary Principi and Dr. Perlin answered the question I had about the demonstration project on delivery a pharmaceutical benefit, in other words, those who had gone to another primary care physician but had come in to see you. This sounds like this has momentum.

And you have also significantly reduced waiting lists. Waiting lists are a big issue with me. It is a very big issue with the veterans' organizations, and the fact that they have been reduced is commendable.

WAITING LINES IN SPECIALTY CARE

But let us go to those waiting lines in the area of specialty care. Am I right, Dr. Perlin, that this is where there is a waiting list? In other words, do you feel confident that you have reduced the waiting list for what we would call primary care and primary care management? The blind veterans' organizations have told me that there is a now a waiting list to get into blind rehab programs.

Dr. PERLIN. Senator, we have made progress in the area of specialty care as well. Our goal for 2005 is that 90 percent of all appointments will be in 30 days or less. In point of fact, we still do have pockets where we need to make improvement. One of the areas you mentioned, blind rehabilitation, is such an area.

For veterans who have suffered acute injury, immediate injury, such as someone coming back from war, we will see them immediately. Those people categorically do not wait.

We need to modernize our programs. In fairness, the programs we have had for someone who has a traumatic loss of vision would be different than for some of our veterans who are aging and because of diabetes, suffer from macular degeneration, a very slow and progressive onset. The programs that we have worked with, the inpatient programs for 6 weeks of care, are both labor-intensive and require a 6-week commitment on the part of the veteran. In point of fact, those veterans do wait, between 4 months and a year, but because of the 6-week commitment, they often schedule that. My point is we need to do better in terms of reducing that waiting list and add new programs to address both causes, trauma and slow disease progression.

Senator MIKULSKI. Well, what you are saying is if you are coming back from Iraq or Afghanistan and you have left a military hospital and there needs to be medical management of the loss or traumatic injury to the eye, they are seen right away.

Dr. PERLIN. Yes, ma'am.

Senator MIKULSKI. For those who have a chronic and degenerative visual situation that comes from, say, diabetes, what you are saying is they might have to wait, but they are not going to wait indefinitely.

What would you say are the specialties most challenging for you right now?

Dr. PERLIN. Specialty care is sort of a reflection of the diseases in society. Cardiology, endocrinology, all of those are areas we are working on, but we are moving the waiting times forward. Again, we have set the standard to be 90 percent of all appointments with-

in 30 days and then 99 percent within 90 days. We believe we will hit the marks on that. We are about 41 days overall as an average wait at the moment.

WORKFORCE SHORTAGES

Senator MIKULSKI. Well, first of all, that is very good, but let me ask a question on workforce shortages. We understand in the medical profession generally there is not a shortage of doctors, but there is a shortage of allied health care people that are able to meet both acute needs as well as chronic management. What are your challenges in the area of nursing, x-ray technology? What should we be looking at to help VA not only have the money to hire but also to have a farm team to help create opportunities for those who would like to come in to health care and then serve their Nation as well?

Dr. PERLIN. Well, thank you, Senator, because that is absolutely right. Our farm team serves the Nation. Sixty percent of all health professionals experience some part of their training in VA. So that is a farm team for the Nation.

As with the Nation, we suffer because of the national nursing shortage. I am proud to say that in contrast to turnover rates of 17 percent annually, VA has retention rates and turnover of only 7 percent among R.N.'s, but there are areas of the country where it is very, very difficult to get R.N.'s into the workforce.

You identified x-ray technicians, nuclear technologists. Some of these allied health professions are areas where in fact some of the salaries in the private sector have gone up disproportionately. I know that legislation, title 38 hybrid, has been something under review, and those are areas that are important for us to maintain both training and adequate staff.

Senator MIKULSKI. Well, Doctor, I am going to ask you, along with the Secretary, if you could give recommendations to us. Where there are national shortages, you could end up in a war for talent which then becomes a bidding war. When we say the private sector, we are not talking about the profit hospitals. We are talking about nonprofit. So you are in a bidding war for many people. Am I correct in that?

So my question would be what would be those ideas which we could both recruit people through either debt forgiveness ideas for service to the VA, like debt for duty, or other scholarship programs? I know this would be a subject of authorization, but also we see these in other fields. I am out now touring the community colleges. There are people who want to come into these fields, but they almost have to be in a work-study environment and this becomes of question of where maybe the VA could play a role and also then have new thinking, new energy.

Dr. PERLIN. Well, thank you, Senator. I absolutely agree with the idea that novel programs such as debt forgiveness such as is used in the military would be one of the mechanisms in which we can bring people in to VA, retain them in VA, and actually provide a service for the country as well.

When we have to contract care, it becomes very expensive. As you know, we have legislation proposed for physician pay reform,

something that has not occurred for over a decade. In all of those areas, that helps us be more competitive.

For nurses in particular, the associate degree nurses can have a full scholarship to attain their baccalaureate degree in VA, and we would appreciate any help in getting that word out because that is a program and your suggestion to emulate that in other areas is, I believe, right on target.

Senator MIKULSKI. Well, thank you very much.

Senator BOND. Thank you, Senator Mikulski.

PERSIAN GULF WAR VETERANS

Mr. Secretary, we all know, of course, that the returning service members, including the Reserve and Guard, are entitled to 2 years free health care upon separation from service after having served in the Persian Gulf. Congress has appropriated $100 million in emergency appropriations in 2003 to assist the war veterans. I would be interested in knowing what specific steps the VA is taking to respond to the needs of returning Persian Gulf War vets.

Secretary PRINCIPI. On the medical side, we have had about 145,000 active duty service members return to our shores, of which almost 20,000, if you will, have come to the VA for medical care and for various reasons, some related to their combat injuries, others unrelated.

We did receive a $100 million supplemental that could be used for either medical or benefits. I have chosen to use the supplemental to assist us in addressing the claims of men and women returning from Iraq and Afghanistan to reduce the backlog. So I think we are making progress on both fronts, and the $100 million supplemental has helped us significantly.

U.S. INTERAGENCY COUNCIL ON HOMELESSNESS

Senator BOND. Mr. Secretary, I spoke earlier on homelessness and the responsibility you took on as chair of the U.S. Interagency Council on Homelessness. My colleague and I are very strong supporters of the mission. Can you tell us briefly what are your goals as chairman of the ICH? How do you ensure that veterans are receiving adequate support from other Federal agencies? I would be interested to know how homeless veterans' access to permanent housing programs is being supported by HUD, for example.

Secretary PRINCIPI. We are addressing the homelessness issue on many fronts. From the VA perspective, with the latest round of grants and per diem, we will have 10,000 beds, the highest number we have ever had, transitional housing beds for homeless veterans.

We need to continue to attack the underlying causes of homelessness, substance abuse, PTSD, serious mental illness, employment-related issues. So it is very, very important that we address the clinical issues if we really want to prevent and overcome homelessness.

I was proud the President named me chairman of the Interagency Council on Homelessness and my goals this year really are to work as hard as I can to achieve the goal of eradicating homelessness in our society in 10 years. Specifically, we will only do so if the Federal agencies involved work together, VA, HUD, HHS, and Labor. To that degree, my goal is to bring all of these agencies

together, to share our resources, and address our respective expertise in housing, in employment, in health care. Last year we had $35 million towards this effort. We have now upped that amount. The President has authorized us to use $75 million of interagency funding. Most of it is funded by HHS.

We have a guaranteed loan program for housing, and we will have three to five projects started this year. We have one in Chicago with Catholic Charities. I am very excited about it. We are going to provide a guaranteed loan to Catholic Charities to open up a homeless shelter in south side Chicago with a VA clinic attached to it. This is a wonderful, wonderful example of what we can do.

With regard to permanent housing, HUD, I think there have been some difficulties getting the section 8 vouchers to the VA. We continue to work with HUD on that issue.

Senator BOND. I think we understand some of the challenges you face in that area, trying to get those coordinations. We will work with you, Mr. Secretary.

COREFLS

My final question is a tough one, but I would like to have you discuss it. Developing an integrated information technology system for the Department is critical. The VA has tried to address this issue by developing an integrated financial management system called CoreFLS. I understand the system had serious implementation problems at Bay Pines VAMC resulting in some serious patient care problems. Have you responded to the problems? Do you believe the CoreFLS is salvageable or should the Department chuck it and start all over again?

Secretary PRINCIPI. Well, I certainly hope it is salvageable. I will not chase good money after bad. We have spent $279 million since the program was launched back in 1998. It is a very, very important undertaking to build a new, integrated financial logistics system for the VA, overcome material weaknesses that the VA has had for many, many years in its financial management systems.

It does have problems. Part of it is the test site that was selected at Bay Pines for this project—it turns out that that was a bad decision because of the other systemic problems that Bay Pines VA Medical Center was having.

To attack this problem, Mr. Chairman, I have done the following. I have made some personnel changes recently. Secondly, I have asked the Inspector General to do a complete and thorough audit and investigation of everything related to this CoreFLS project from how the contract was implemented, right on down the line.

Additionally, I have asked our CIO, our chief information officer, to contract with an independent agency or organization to assess the validity of CoreFLS and whether we should go forward with it, and I expect a report from my CIO in 60 days. So I am watching it very, very carefully. This was designed to be a close to $500 million project. We need to take appropriate steps.

Senator BOND. Thank you. I appreciate that summary. Obviously, there is a lot of money that I hope is not down a rat hole, but obviously we need a good system and I think it is time to step back and take a very careful review and see where we are going.

Secretary PRINCIPI. I will report to you, Mr. Chairman, Senator Mikulski, as soon as I get the final report from the IG and the report from the independent team that will be addressing it over the next 60 days and then discuss going forward at that time.

Senator BOND. Thank you, Mr. Secretary. That concludes my questions. I will turn now to Senator Mikulski.

Senator MIKULSKI. Thank you, Mr. Chairman.

For my final round I have one question about claims processing and then for our Afghan-Iraqi vets.

CLAIMS PROCESSING

On claims processing, I am back to my favorite topic: waiting lines and waiting times. As you know for some years, those who filed disability claims have had very long waiting times and very disappointing and frustrating experiences with claims processing. Now, as I understand it, you have been able to substantially reduce that waiting time. You said that in your testimony. But then I am puzzled by the fact that there is going to be a reduction of 540 staff from the VA Benefits Administration.

So here is my question. How are we doing on the claims time? Again, if you have a disability, you should not have to wait in line to get that for which you are both eligible and entitled. Then, second, presuming progress has been made, are we now about to trip ourselves up?

Secretary PRINCIPI. Sure. A very important issue, Senator Mikulski. As I indicated, we are making great progress. We are clearly not there yet. This is a moving target and no sooner do I feel that we have got everything under control and then something else happens. The court decision will come down and say a veteran had a claim. It had 15 conditions and you may have approved 14 and you denied 1, but you have got to hold the claim for a year to give the veteran a chance to submit additional evidence, or concurrent receipt. Veterans, in order to become eligible, may want to reopen their claim to get an increased disability rating to become eligible for CRSC. So it is constantly changing. The landscape is constantly changing.

The 500 people you mentioned—only 35 of those will come out of the disability compensation arena. VBA, the Benefits Administration, has as you know, education, housing, vocational rehabilitation and pension. We have done some consolidation in pension. Thereby we can reduce a little bit of our end strength.

Obviously, I am concerned. It is a very high priority of mine. I think we are okay. You gave us 1,800 people over the past couple years.

Senator MIKULSKI. Right and then I see you are letting off 500.

Secretary PRINCIPI. They are not actually coming from that. How many people do we have in Benefits Administration? About 11,000. So they will be coming from other areas.

But the point I feel is important to make is it takes a couple years to get those people up and trained. Now that they are trained, they should be much more productive.

Secondly, I think you have a right to demand that like the private sector that is showing productivity improvements because of

technology that you are investing with us, we need to demonstrate some productivity improvements too.

So I think the combination, Senator Mikulski, will allow us to do so. But obviously——

Senator MIKULSKI. Well, Mr. Principi, I am going to ask you and your management team to stand sentry. I think we have come a long way over the last several years in reducing the waiting line for disability claims and at the same time ensuring those eligible and therefore entitled to get their benefit and prevent abuse in the system. So we do not want to lose those gains and then in the anticipation of the Iraqi-Afghan vets coming home, many of whom do bear these permanent wounds of war that we do not want, as they then apply for benefits, to have to go through the frustration about applying.

IRAQI-AFGHAN VETERANS

But this then takes me to the Iraqi-Afghan vets. First of all, I think that VA is going to be hit by the three populations. No. 1, we have expanded the eligibility opportunities to come to VA. No. 2, the Vietnam vets are coming of age, and I believe that they are going to turn more and more to VA because of the failure of health care in other areas, with the loss of a job or not being eligible for Medicare. Essentially the people between 55 and 64. You will be the health care providers not of the last resort in a negative sense. And then now we have these men and women who will be returning from Iraq and Afghanistan.

My question is, No. 1, are we ready and do we need additional money for that?

No. 2, there seems to be, because of the nature of the war against us, an incredible amount of orthopedic injuries. My visit to Walter Reed and contacts with constituents talk about the prosthetic issues. So my question is, are we ready? Second, are we paying particular attention to this? And third, I am very troubled by the cut in VA medical research. The doctors over at Walter Reed are telling me that there is not a lot of work going on in the area of prosthetics either at Walter Reed or with themselves, at least with upper body.

Have you been over to Walter Reed?

Secretary PRINCIPI. Yes, many times.

Senator MIKULSKI. I do not have to describe to you what I met. But when you walk up to a young man and you want to shake his hand and the injury is there, you do not go home at night and just read memos. You really want to be on the edge of your chair to help them.

Secretary PRINCIPI. It is pretty tough. I go up as much as I can.

Senator MIKULSKI. Well, God bless you for that.

Secretary PRINCIPI. I think we are ready in the short term, Senator. I think because of what you have done and almost a $3 billion increase in 2004 and I am sure we will have a very good increase in 2005, I think we are fine.

But I do not know about the long term in the sense of we have 25 million eligible today. As you indicated, my cohort of now 60's, approaching 60, medication and everything is increasing, visits, et cetera. So if you want us to focus on the service-disabled and the

poor and those in need of specialized services, I think we are going to be fine. But if there is going to be the need to expand the patient population to those who may have higher incomes and may have some other options—they may not be great options. They may be closing on them—then I think the long term is going to be problematic. The system is not built for anywhere near 25 million veterans, and we are almost growing too fast. The beauty of these outpatient clinics throughout Maryland, throughout Missouri is that veterans have access, but there is going to come a time when they are going to go in for an appointment, but then 6 months later they are going to have to go in for an inpatient open heart or a new hip. Once you get them in the system, then they are in the system for everything except long-term care and that is 70 percent or greater. But long term it could be difficult to balance all this out. And are we going to have to go the contract route?

Senator MIKULSKI. Mr. Secretary, I am going to ask you to give us a white paper on this because we have got to meet the needs immediately of those veterans coming home that are being discharged from the hospitals, many of whom return to rural communities. As you know, when I make those phone calls in Maryland to those who have lost a soldier or a sailor or a Marine, a lot of them are from our rural communities or they are from minority communities. They are going to come back, their brothers and their sisters and their cousins, and we just have to be there. So just know I think this is where we have to be in partnership.

[The information follows:]

WHITE PAPER ON VA SEAMLESS TRANSITION TASK FORCE

BACKGROUND

Secretary of Veterans Affairs, the Honorable Anthony J. Principi, created a VA Task Force for Seamless Transition for Returning Service Members on August 28, 2004. The Seamless Transition Task Force meets weekly and is co-chaired by Dr. Michael Kussman, Acting Deputy Under Secretary for Health and Chief of Patient Care Services in the Veterans Health Administration (VHA), and Carolyn Hunt, Deputy Director of the Compensation and Pension Office in the Veterans Benefits Administration (VBA). The task force was charged with:

—Improving collaboration between VHA, VBA and DOD on care of returning Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) veterans;
—Improving communication and coordination among VHA, VBA and DOD staff in providing health care services and VA benefits applications to OIF/OEF veterans;
—Ensuring VA staff is educated about the needs of this new group of veterans; and
—Ensuring appropriate policies and procedures are in place to enhance seamless transition of health care and access to disability services.

MTF LIAISONS FOR SEAMLESS TRANSITION

The task force identified the five major Military Treatment Facilities (MTFs) where seriously injured and ill OIF/OEF active duty service members were being treated, and assigned VA staff to work side by side with MTF staff to assure seamless transition for OIF/OEF active duty service members and veterans. VA staff were later assigned to two additional MTFs, with another VHA staff member providing liaison to all other MTFs. The VHA social workers assigned to the MTFs serve as liaisons and arrange transfer of health care, inpatient and outpatient, from military hospitals to VHA health care facilities. They also arrange for TRICARE authorization so that VHA facilities can provide health care to active duty service members, and they enroll active duty service members in the VA health care system prior to transfer. VBA benefits counselors educate service members about VA benefits and help them apply prior to military separation.

VHA staff are assigned as follows:
—*National Naval Medical Center (Bethesda)*.—Full time VHA social worker;
—*Brooke Army Medical Center (San Antonio)*.—Full time VHA social worker;
—*Darnall Army Medical Center (Fort Hood)*.—Full time VHA social worker;
—*Eisenhower Army Medical Center (Fort Gordon)*.—Part time VHA social worker;
—*Evans Army Hospital (Fort Carson)*.—Full time VHA nurse;
—*Madigan Army Medical Center (Fort Lewis)*.—Two full time VHA social workers;
—*Walter Reed Army Medical Center*.—Two full time VHA social workers;
—*All other MTFs*.—A part time VHA social worker.

VHA FACILITY POINTS OF CONTACT AND CASE MANAGERS

Each VHA facility identified a Point of Contact (POC) to work with the VHA social workers serving as liaisons to the MTFs. The POCs arrange inpatient care, outpatient appointments, and all necessary equipment, supplies, orthotic devices and prosthetics for OIF/OEF active duty service members and veterans. Each facility also identified a nurse or social worker case manager who is assigned to all OIF/OEF active duty service members and veterans whose care is transferred to that facility. The case managers maintain contact with the MTF staff, particularly for those active duty service members who are still awaiting Physical Evaluation Board results regarding medical retirement or medical separation from active duty. Lists of the VHA and VBA liaisons, the VHA POCs and case managers, and the VBA case managers are updated weekly and are available on the VA Intranet web page.

VA GUIDANCE ON SEAMLESS TRANSITION

Secretary Principi sent a letter to each VA employee stressing the importance of seamless transition for returning OIF/OEF active duty service members and veterans. The VA Seamless Transition Task Force developed the following:
—Guidance to VHA health care facilities and VBA regional offices on the roles of the VHA liaisons, POCs and case managers and the VBA benefits counselors and case managers. The guidance includes a script for front-line staff to use when interacting with veterans.
—A video, "Our Turn to Serve", which was shown to all VA employees.
—A VA Intranet web page for OIF/OEF where all policy guidance, resource information, task force minutes, and lists of VHA and VBA liaisons, POCs and case managers is available to VA staff.
—A new OIF/OEF icon on the VA Internet web page with information about VA, DOD, Reserve and Guard Affairs, TRICARE and other resources are available.
—Pamphlets, brochures and other outreach materials for OIF/OEF regular active duty, members of the Reserves and National Guard, veterans, and family members. Soon-to-be completed products include laminated cards with VA and DOD phone numbers and web addresses as well as an in-flight video welcoming OIF/OEF active duty service members and veterans home and offering VA benefits and services.
—VBA staff continue to conduct briefings on VHA and VBA benefits at Transitional Assistance Program (TAP) meetings. VHA staff have been invited to attend. Briefings are also conducted at Reserve and Guard units during weekend drills.
—A proposal for a permanent Seamless Transition office at the Department level to carry on the activities of the task force in the future.

THE TRANSITION LINK

Having VHA social workers at the major MTFs assures that those active duty service members who are to be discharged from the MTF but who still need rehabilitation and other heath care services are referred to VHA. The VHA social workers arrange for transfer of care, inpatient and outpatient, for all service members referred by MTF staff. The VHA social worker meets with each service member and discusses VHA health care services, developing a plan for transfer to the VHA facility that can provide the needed care and is closest to the service member's home.

For service members needing specialty services, such as treatment or rehabilitation for spinal cord injury, traumatic brain injury, visual impairment, amputations, and serious mental illness, the VHA social worker will arrange transfer to the VHA facility that can provide that level of care. The VHA POC and case manager at the receiving facility arrange for inpatient and outpatient services as well as for all necessary equipment, supplies, orthotic devices and prostheses. The VHA case manager makes contact with the active duty service member prior to transfer and with the service member's family. The case manager can assist the family member with

transportation and lodging needs if the VHA facility is not within commuting distance.

For service members who need less specialized care, transfers are made to all VHA facilities, including community-based outpatient clinics. Community-based outpatient clinics provide access in rural parts of the country.

Service members also have the option of utilizing TRICARE providers while they are still on active duty. The VHA social workers serving as liaisons at the MTFs assist service members in choosing treatment options that include TRICARE and VHA.

For those who are already separated or retired from active duty, post-MTF treatment can include VHA health care facilities, including community-based outpatient clinics and services received by community providers via fee basis or contracts.

Senator MIKULSKI. Senator Leahy followed one course of questions. See, I follow another course. I do not think we ought to talk about Republicans or Democrats. I think when we talk about veterans, we are the Red, White and Blue Party. I tell you, when those guys sign up, nobody asks them their political party. When they face these ghoulish and horrific circumstances, it is not about politics. It is about our country.

The other thing I do know is that you are looking at innovation, and I want to thank you for that. We contacted you because in the Cumberland outpatient clinic, they were losing their opportunity for visual care, not the sophisticated type care, Dr. Perlin, that might be available at the University of Maryland, VA or even a mandated visit at Wilmer Eye Clinic at Hopkins, but it was for the certain basic care which would be handled through an optometrist. And you contracted with a Wal-Mart.

Now, when I first heard it, I thought, "Holy hell. Are we going to Wal-Mart for the VA? I do not want Wal-Mart medicine for my vets." But when we looked at it, that was who was available in the community and we had a way where there would not be a waiting line for veterans.

ADDITIONAL COMMITTEE QUESTIONS

So we are looking for innovation, and I have some other ideas on some of this that I would like to then discuss with you. I know that our time is up, but we need to really look now for the immediate return and then we need to look ahead and to prepare ourselves. When everybody wants to stand up for their troops, I think we need to stand up for them right here and today, meet the budget needs and lay the groundwork for what could come in the future.

So, thank you.

Secretary PRINCIPI. Thank you very much.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR CHRISTOPHER S. BOND

PRIORITIES

Question. Given the likely funding constraints for our subcommittee, what are your top three funding priorities for the VA?

Answer. While VA believes all its programs are a high priority, we are well aware of the funding constraints the subcommittee faces and recognize that difficult budget decisions must be made. However, I have gone on record stating that my three highest priorities are:

—Provide timely, high quality health care to our core constituency—veterans with service connected disabilities, those with lower incomes, and veterans with special health needs;
—Improve the timeliness and accuracy of claims processing;
—Ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines.

CARES—CLOSURES

Question. Mr. Secretary, you have heard many negative comments on CARES because of the potential hospital closings in the plan. Without going into specifics, I believe that closures or realignments are necessary in cases where the facility is underutilized and where these closures will be replaced with other services that will provide better care for more veterans.

There appear to be some misunderstanding about CARES because some people believe that the proposed closures will reduce services or access for veterans. My understanding is that by closing unneeded facilities, the VA will re-direct its cost savings to open more outpatient clinics or purchase contract care that is located closer to more veterans. Further, the VA will be able to use proceeds from enhanced use leases of closed facilities to pay for more medical care services for more veterans. Therefore, more veterans will benefit from improved access under CARES. Can you respond?

Answer. VA has been committed to developing a plan that addresses the future needs of enrolled veterans. Extensive data based plans were developed for each of VA's 77 market areas. All plans identified the capital investments and realignments that are required over the next 20 years to provide cost effective, accessible, quality health care in facilities that meet the physical requirements for the delivery of health care services.

On May 7, 2004, I released my decision, which will afford more opportunities for veterans to benefit from improved access. Under the guidelines of this decision, VA will develop a national plan for directing resources where they are most needed; preserving VA's mission and special services; and, at the same time, continuing to provide high-quality care to more veterans in more locations.

My decision includes the development of an additional 156 CBOCs and calls for taking advantage of all opportunities to purchase contract care more effectively. VA will also continue to work with DOD to improve sharing to enhance benefits and services to veterans, service members, and their dependents, while improving use of taxpayer resources.

Successful implementation of CARES will rest in large part in VA's ability to effectively manage its vacant and underutilized space. In the last 10 years VA has made numerous changes to the enhanced use lease process. It is critical that VA continue to improve its capabilities. A cross-organizational team has made recommendations to further improve the timeliness and effectiveness of the EUL process. Through CARES VA expects to reduce its current vacant and underused space by 42 percent by 2022.

Overall, the comprehensive restructuring of VA health care will improve the way VA delivers care. I wish to emphasize that health care services for veterans will not be reduced.

Question. Lastly, under the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, the VA is required to prioritize its CARES projects based on six criteria. The first and most important criterion is that the project replaces or enhances a project that is expected to close. I believe that this criterion helps ensure there is continuity in service for veterans. Do you agree?

Answer. I agree that the criterion will help assure continuity of service to veterans. It has always been a major tenet of the CARES process that no realignments, closures, or other changes be made to VA health care services in a particular locale without first ensuring the continuation of these services, whether through other VA facilities or through contracts with other health care providers in the community.

Moreover, to ensure compliance with the law while implementing my decision on CARES, VA will use its existing capital development process to revise the weights of its criteria so that patient and employee safety concerns are ranked as the second most important factor in consideration for construction funding. This process will be completed in time to be operative for submission of VA's 5-year capital plan, scheduled for this month.

TRANSITIONAL PHARMACY BENEFIT (TPB) PILOT

Question. Mr. Secretary, I commend you for implementing a pilot program that allows veterans to fill privately written prescriptions at the VA. Under the Transi-

tional Pharmacy Benefit (TPB) program, preliminary data indicates that 8,298 or 20 percent of the 41,167 eligible patients have participated in the program.

To what degree has the program help reduce the waiting list?

Answer. The TPB program was designed to provide prescription drug services to veterans on the waiting list to ease the burden of out-of-pocket prescription drug expenses for veterans whom we were not able to serve within 30 days of the appointment request. We have no data explicitly linking the TPB program with system-wide reductions in the waiting list.

Question. When the VA originally announced this program, it estimated that over 200,000 veterans would be eligible to participate but now only 41,000 are eligible. Why has this number changed so drastically?

Answer. Throughout the TPB program development period, various eligibility policy options were considered, each of which impacted the potential pool of eligible program participants. The number of 200,000 veterans represented the best estimate available at the time the program was initially being developed.

For example, as data refinements were made, some of the 200,000 patients originally included in the estimate were found to already have had medical care appointments and were excluded. Similarly, another portion of the original 200,000 projected patients were found to already have received prescriptions from VA and were excluded. More detailed explanations of the gradual reduction in eligibility numbers can be found in the VA Office of the Inspector General's (OIG) report on the program entitled Evaluation of VHA's Transitional Pharmacy Benefit.

Question. What was the original cost estimate of the program? What is your most current cost estimate of the program? How much money have you saved in administrative costs by streamlining the process in obtaining prescription drugs?

Answer. An early cost estimate for the TPB program (i.e., before final policy decisions reduced the pool of eligible participants from 200,000 to 41,000) was $59 million. Program costs through the first 20 weeks have been calculated to be $4,183,167 ($915,126 in estimated administrative costs and $3,268,041 in drug ingredient costs).

The TPB program has increased, rather than decreased, the administrative prescription processing costs due to the increased labor requirements associated with contacting private physicians to discuss conversion of prescriptions to formulary items and other formulary-related issues.

Question. Based on your preliminary findings, do you believe the program has been a success and do you think it should be expanded?

Answer. For those patients who chose to participate in the TPB program, it clearly met its original intent of easing the burden of out-of-pocket prescription drug expenses for veterans whom VA was unable to serve within 30 days of their appointment request, and is therefore considered a success. In this regard, VA is not opposed to continuing to offer the TPB program to other patients so long as they continue to meet the original three eligibility criteria, which were the following:

—they must have been enrolled in the VA health care system prior to July 25, 2003;

—they must have requested their initial primary care appointments prior to July 25, 2003; and,

—they must have been waiting more than 30 days for their initial primary care appointments as of September 22, 2003.

Question. I have heard that some VA medical personnel opposed the implementation of this program. Anecdotally, some medical facilities may have taken some extraordinary steps to bring their waiting lists down so they did not have to implement the pharmacy program. For example, my staff heard that one hospital forced personnel to work overtime to see the patients on the waiting list. Is there any truth to these rumors? What steps were taken to ensure that the program was implemented in a fair and objective manner?

Answer. As indicated in the Congressional hearing on the Transitional Pharmacy Benefit (TPB) on March 30, 2004, VHA has worked diligently and aggressively to reduce the list of patients on the wait list for their first clinic appointment and has demonstrated meaningful reductions in the wait lists. Many facilities extended clinic hours to nights and weekends, scheduled staff to work overtime, and/or hired additional staff to reduce appointment wait lists.

The time period from the TPB program approval to implementation was compressed and VHA staff worked diligently to achieve the best possible program implementation in the time available for rollout. In order to encourage consistent system-wide program implementation, VHA took the following actions:

—Prior to and during the TPB program rollout, VHA conducted a series of conference calls with pharmacy, eligibility, information technology, and other sup-

port staff to provide an overview of the TPB program and to provide detailed instructions for program implementation.
—TPB program overviews were also provided to senior VISN and Medical Center clinical and administrative managers on separate conference calls.
—Periodic program updates were provided to field staff via blanket e-mail messages from the pharmacy, information technology, and eligibility program offices. These messages also provided an electronic forum for field staff to discuss operational issues and or seek clarification on specific TPB implementation issues.
—VHA also monitored waiting lists and facility specific TPB participation to track program participation, cost and utilization trends.
—VHA established a website with TPB reference and educational information geared to VA staff, patients and private sector providers.

ACCESS STANDARDS

Question. Mr. Secretary, I commend you for reducing the waiting list of veterans waiting more than 6 months for a medical appointment. I also commend you for prioritizing care for veterans with service-connected disabilities. Nevertheless, I remain concerned about veterans' access to health care. Despite the establishment of access standards since 1995, the VA has not been required to meet them. In fact, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans found that "there is persistent concern about the inability of VA to provide care to enrolled veterans within its established access standards."

Do you believe that the VA should be required to meet its access standards? What steps have you taken to hold VA staff accountable for meeting the Department's access standards?

Answer. Yes, VA will continue to meet its access standards and use all necessary resources and private-sector initiatives to assure that our veterans receive needed care in a timely manner.

VA holds staff accountable for meeting the Department's access standards through performance contracts. The fiscal year 2004 performance contracts include a combination of standards for access. They are combinations of responses from veterans through surveys on how long they waited and percentages of appointments within 30 days of the Veteran's desired appointment date for veterans requesting the next available appointment.

WAITING TIMES

Question. The VA has established a goal of seeing 93 percent of all patients within 30 days and in fact, the VA is actually seeing almost 94.5 percent of all patients within this period. However, the VA's most recent data indicates that 48 percent of new patients are being seen within 30 days.

First, does the VA independently verify the accuracy of its wait time data? Is it possible for some medical centers to game the system?

Answer. The General Accounting Office (GAO) audited VA wait times in 1999–2000 and most recently in VISNs 6 and 9. Veterans receiving VA care are also surveyed about their experience accessing our system. We also track complaints on access. All three sources give an independent check on our internal wait time calculations. In addition, our wait time numbers are trended, and variances between what is reported and what is expected are singled out for review with leadership.

The Under Secretary for Health (USH) read a memo on March 26, 2003, to senior VHA leadership stressing his expectations of the highest managerial and ethical practices when reporting wait times. The Acting USH recently sent an e-mail to all employees regarding ethical conduct and the need to report unethical practices to include "gaming." The Acting USH asked staff to e-mail him directly if other channels of reporting fail. The VA IG also independently evaluates waiting times.

Question. Second, what is the reason for the poor access rate for new patients? Does this poor access rate include new Priority 1–6 patients?

Answer. New patients typically request the next available appointment date. Established patients typically request follow-up appointments. It is easier to balance supply and demand for established patients who need to be followed up at predictable dates in the future, than it is to balance supply and demand for new patients who request the first unscheduled appointment available.

The 48 percent of new patients seen within 30 days (referenced in your previous question) may include Priority 1–6 patients; however, facilities are reviewing their appointment logs to see service connected veterans within 30 days. VA is able to take care of its established patients in a reasonable time frame. Veterans waiting for an initial appointment have more extended waits. VA's continued growth, dif-

ficulty recruiting, lack of a physician pay bill, and geographical variances all account for the access issues with new patients.

Question. Lastly, your data indicates a wide variance among the networks on access rates. What are the reasons for this performance variance? Do you believe VA's performance needs to be more consistent across networks?

Answer. Veterans' demand for services is increasing at different rates between networks. VA operates as a national health care system and is working on implementing its Advanced Clinic Access program to improve access and make office practice efficiencies. While some networks will lag behind others in implementing Advanced Clinic Access changes, it is ultimately the uneven growth in demand across VISNs that results in inconsistent performance.

CARES—GENERAL

Question. Mr. Secretary, the CARES Commission released their report to you on February 12, 2004 and you are now reviewing the report. The report includes a wide range of recommendation covering individual medical facilities and broad health care issues.

First, do you have any general concerns about the Commission's recommendations? For example, do you have any concerns that the Commission consistently applied its guiding principle of reasonableness to every location? Do you believe the Commission's recommendations were adequately supported by benefit and cost information?

Answer. It is my belief that the Commission did a magnificent job in providing a consistent level of reasonableness and fairness in all of its recommendations, given the enormity of the task I set before the Commission and the relatively short time it had to produce its report. I have every confidence that they had access to and made optimal use of the best data available, including cost and benefit information. I cannot commend them enough for their valuable contribution to this effort.

Question. Second, do you plan to accept or reject or modify the Commission's recommendations in their entirety or on an individual basis?

Answer. I released my decision on May 7, 2004, and have shared it with the Committee. I have formally accepted the CARES Commission Report although I will use the flexibility it provides to minimize the effect of any campus or service realignment on continuity of care to veterans.

Question. The Commission recommended the creation of a separate entity that would be charged with the disposition of VA's excess properties and land. What are your thoughts on this recommendation? Does the VA have the current capacity to carryout this disposition function in an efficient and cost-effective manner?

Answer. The CARES Commission recommended that the Department ensure that efficient processes are in place for property disposal and that sufficient expertise is available, including the use of private sector professionals. As indicated in the question, the Commission suggested that perhaps a separate organization might be created. We agree that processes and procedures need to be in place to support timely disposal. This area of expertise is within VHA's Office of Facilities Management and in the Office of the Assistant Secretary for Management, of which both utilize private sector services. Both of these elements are provided legal support by the Office of General Counsel. A cross organizational team has made recommendations to further improve the timeliness and effectiveness of the enhanced use lease process. These recommendations include delegating authority within appropriate thresholds to newly created Chief Asset Manager and Chief Logistics Officer at the regional area. VA will also increase real property management expertise at the VISN level, and ensure VA personnel have access to the financial, legal, and marketing expertise to manage complex real estate projects.

The Department does not presently have the authority to directly dispose of property except in very limited situations. Most disposals, if not legislatively directed, are through the General Services Administration, who handles the real estate aspects of the transaction. There have been few disposals historically. The extent to which organizational changes might be beneficial will depend on whether VA receives the authority to dispose of property and the volume of disposals

CLAIMS PROCESSING

Question. Mr. Secretary, I commend you for the substantial improvement in reducing the processing times for compensation and pension claims. I am, however, concerned about the proposed budget reductions in the administration's request when the VA expects a projected workload increase. I am especially concerned about the Department's ability to meet the workload resulting from the partial ban on "concurrent receipt" and returning veterans from the War in Iraq.

Are these legitimate concerns? Can the VA adequately handle its projected workload despite the proposed staffing reductions in the budget request?

Answer.

	2004 Estimate	2005 Estimate	Difference
Compensation Direct FTE	6,035	6,040	+5
Pension Direct FTE	1,451	1,230	−221

VBA's primary compensation and pension (C&P) claims processing goals for fiscal year 2004 are to reduce the rating inventory to 250,000 claims, improve rating timeliness to 100 days, and increase the quality of rating claims processing to 90 percent. An inventory of 250,000 claims will represent a normal workload without an associated backlog. With its workload under control as we enter fiscal year 2005, VBA will be able to maintain optimal performance despite a decrease in personnel.

Over the past several years, we have implemented a number of initiatives that will help us sustain our improved performance into 2005 and beyond:

—Since 2001, VBA has added 1,800 decision makers in the C&P business lines. As these new employees have gained proficiency in their duties, VBA's performance has dramatically improved.

—Specific performance priorities, including station inventory, timeliness, and quality levels, have been incorporated into the Regional Office Directors' Performance Appraisal Plan since fiscal year 2002. Additionally, national performance plans were effected 2 years ago for the key technical positions of Veterans Service Representative, Rating Veterans Service Representative, and Decision Review Officer. Individual productivity and quality requirements are included in each of these plans.

—In its May 2002 report, the VA Claims Processing Task Force noted that the work management system then in place contributed to inefficiencies in claims processing. As a result, a new model was instituted nationwide at the end of fiscal year 2002. It reengineered work processes to reduce the number of tasks performed by decision-makers, and incorporated a triage approach to incoming claims. The efficiencies gained through this reorganization are evident in VA's continued performance improvements.

—Three Pension Maintenance Centers were established in fiscal year 2002 to consolidate this very complex, labor-intensive component of VBA's workload. This consolidation is now complete and has resulted in a streamlined pension maintenance process requiring fewer resources.

—The proposed pension staffing reductions also include employees adjudicating the remaining pension work. Public Law 107–103, the Veterans Education and Benefits Expansion Act, eliminated the need for rating decisions for certain categories of pension claimants, thereby reducing the amount of work and time required to process these claims.

—In 2003, responding to a court decision that invalidated a VA regulation to the extent that it permitted the Board of Veterans' Appeals to consider evidence not already considered by the agency of original jurisdiction (AOJ), without remanding the case to the AOJ for initial consideration or obtaining the claimant's waiver of the right to initial AOJ consideration, VBA established the Appeals Management Center (AMC). Rather than sending remanded claims back to regional offices, the AMC develops these cases and makes decisions based on the evidence received. This enables regional offices to use their resources in other areas of claims processing.

—New training tools and information technology (IT) applications have had a positive impact on worker productivity and quality. National training packages—particularly the Training and Performance Support System (TPSS)—facilitate consistent and thorough training nationwide, increasing employee proficiency more quickly and improving the quality of work.

—Programs such as Rating Board Automation (RBA) 2000, Modern Award Processing, and SHARE have automated processes previously performed manually, hence accelerating many aspects of claims adjudication and avoiding some of the errors inherent in manual processing.

VISN STRUCTURE

Question. The President's Task Force (PTF) found last May that the VA's veterans integrated systems network (VISN) structure "resulted in the growth of disparate business procedures and practices." Further, the PTF's report stated that the "VISN structure alters the ability to provide consistent, uniform national program guidance in the clinical arena, the loss of which affects opportunities for improved quality,

access, and cost effectiveness." Due to these findings, the PTF recommended "the structure and processes of VHA should be reviewed."

Do you agree with the PTF's findings? If so, how have you responded to these findings? Do you believe the VISN structure needs to be altered?

Answer. Recommendation 4.1 in the PTF Final Report indicated that the Secretaries of Veterans Affairs and Defense should revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments. We agree that more effective coordination between the two Departments is desirable, but we also recognize the difficulties in coordinating activities between two structurally different organizations. However, both VHA and DOD Health Affairs are working to improve coordination activities. Recently, VHA approved five new full-time equivalents to serve as liaisons with the three new TRICARE regions under T-Nex, with TMA headquarters in Aurora, CO, and with Health Affairs in Washington, DC.

Although we are not averse to altering the VISN structure as necessity dictates, at this time, we have no plans to change it.

RESEARCH

Question. The budget request proposes a $21 million cut to the medical and prosthetic research account. Further, there has been some controversy on proposed changes to VA's research programs.

What is the justification for this proposed reduction? Is the Office of Research still pursuing changes to its research agenda so that its programs will more directly benefit veterans?

Answer. VA's medical and prosthetic research program contributes significantly to veterans' health care, and the program enjoys the full support of the Department. Fiscal constraints for all non-Defense/Homeland Security programs forced careful evaluation of all facets of health care delivery to ensure that the Department proposed a fiscally responsible budget that addressed veterans' needs. In addition, VA believed that it would be able to offset the reduction with reimbursements from pharmaceutical firms for the indirect costs associated with conducting research. Accordingly, VA determined that it could temporarily reduce appropriated research funding without directly harming its ability to recruit and retain physicians.

The Office of Research and Development continues to evaluate its programs to ensure that they best serve the Nation's veterans. This on-going process began in the 1990's and has resulted in important medical discoveries that have improved veterans health and reduced medical care costs. The most recent program revision has resulted in increased emphasis on prosthetics and rehabilitation that addresses the long-term needs of severely wounded veterans returning from Southwest Asia.

CARES—CAPITAL COSTS

Question. The Draft National CARES plan developed by the Under Secretary for Health included an estimate of the capital costs for implementing CARES. The CARES Commission, however, did not provide a capital cost estimate.

Will you provide us a capital cost estimate for CARES for those recommendations you accept?

Answer. As we build our fiscal year 2006 budget, we will assess what amount should be funded in fiscal year 2006 for CARES and estimate the outyear funding stream. Priority will be given to implementing the long-range plan identified in my May 7 CARES Decision Report; while recognizing that this plan must fit with the overall spending caps. Specific project information will be included in the forthcoming 5-year Capital Plan.

ACTIVITY-BASED COSTING

Question. Some Federal agencies and private healthcare providers are using activity-based costing to analyze and break down the cost of a medical procedure, test, or service into cost information that can used to achieve financial and operational efficiencies. I am aware that the San Diego VA Medical Center is currently utilizing activity-based costing software in various lab departments.

How well is activity-based costing software working at the VA San Diego Medical Center?

Answer. The VA San Diego Healthcare System, Pathology and Laboratory Medicine Service (PALMS) is utilizing an activity based costing (ABC) software program as a supplement to DSS data as an aid in strategic and tactical management decisions. The laboratory began using this software as part of a beta-testing agreement about 3 years ago. There are several benefits to this type of cost analysis, including

improved identification of high-cost components to laboratory tests, data-driven decision-making, and more accurate budget projections. While utilization of this software is still in the development phase in this facility, we feel that full implementation would realize decreased costs for the laboratory services provided.

There are many benefits associated with activity based costing in general, however the following specific information will address the particular software that has been in use at the VA San Diego. The ABC software provides a very specific breakdown of costs associated with each product (test) performed. This allows management to identify outliers and implement improvements to reduce overall cost. Additionally, this functionality aids in ensuring the accuracy of costing information, such as labor, supply, and overhead allocations. This program has the ability to "simulate" increases in workload or changes in methodology and recalculates the projected costs. Based on this information, PALMS can make determinations regarding increasing or decreasing sharing agreements, new equipment purchases, or utilizing contract services or laboratories. The costing information is virtually real time, compared to the current method, which has a lag time of one quarter to demonstrate operational changes. Some additional benefits include the ability to benchmark against comparable laboratories and a budgeting module. The budgeting module utilizes current costs and expenditures, but also provides for projected changes in workload or methods.

The full implementation of activity based costing in the laboratory would aid in reducing costs, improving financial efficiency, and improving the accuracy of current costing methods. This facility currently performs laboratory testing for veteran patients, local area healthcare facilities, Department of Defense, and various research studies. The ABC software would insure external customers are charged appropriately for services rendered and decisions to expand external sharing are data-driven and justifiable.

VA–DOD COLLABORATION

Question. For several years, there have been numerous efforts to promote health care collaboration between the Department of Defense and the VA. Most recently, the Bob Stump National Defense Authorization Act for fiscal year 2003 directed DOD and VA to establish a joint program to identify and provide incentives to implement, fund, and evaluate creative health care coordination and sharing initiatives between the two departments.

Can you give us a status and any initial findings in implementing this new program?

Answer. The Treasury account required by the law has been established, and the $15 million contributions that each Department is required to contribute annually have been made. The DOD–VA Health Care Sharing Incentive Fund Memorandum of Agreement is being finalized for approval. On November 7, 2003, the Financial Management Work Group of the Health Executive Council (HEC) issued the first call for proposals, which were due in early January 2004. A work group of VA and DOD staff has completed its review of the 57 proposals submitted. The Financial Management Work Group approved 28 projects to advance to the second round of evaluations. Second round applicants are being asked to submit a business plan and a business case analysis by May 21, 2004. Final selections are not expected until this summer.

The Incentive Fund has generated a lot of interest. Some of the lessons learned to date include:

—VA and DOD partners need to coordinate early on their submissions.

—Time frames for submission of proposals need to allow sufficient time to go through VA's and DOD's chains of command.

—Corporate information technology activities and initiatives need to be better communicated to avoid development of submissions that are not congruent or duplicative with National projects or solutions.

—Partners need to recognize that the Incentive Fund process does not supercede normal administrative requirements of either Department, which need to be factored into the time frames for submission of proposals. For example reviews by governing boards for purchases of major pieces of equipment still need to go through VA's and DOD's review boards.

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

COMPENSATION AND PENSION CLAIM PROCESS

Question. Discuss the tools these programs—Virtual VA project; Compensation and Pension Evaluation Project; the Training and Performance Support Systems Project; and the Veterans Service Network—will give to improve the claims process, and does this budget help VA to accomplish our goals there?

Virtual VA

Answer. Virtual VA is an ongoing initiative designed to replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically. It will provide a long-term solution to improving the quality of claims processing for veterans and their dependents through enhanced file management, a reduced dependency on paper, and increased workload management across the business enterprise. Virtual VA is currently being used to support the pension workload at three Pension Maintenance Centers (Philadelphia, Milwaukee, and St. Paul). The majority of the pension maintenance work has now been centralized to these three locations and we expect continued improvement in performance. Virtual VA also provides simultaneous access to pension documentation by VBA users and Veterans Service Officers across the country, allowing for immediate response to veterans' inquiries and improved levels of service. Through the use of Virtual VA at the Pension Maintenance Centers, we are learning how to optimize this valuable tool and intend to continue our deployment to other programs after its effectiveness is validated through pension maintenance processing.

Compensation and Pension Evaluation Redesign (CAPER)

CAPER is an ongoing initiative designed to improve services by enhancing the disability exam request and return process, as well as the disability evaluations process, across the Veterans Benefits Administration, the Veterans Health Administration, the Board of Veterans Appeals, and contract examiner organizations by using redesigned business processes and leveraging information technology wherever possible. CAPER will help standardize the quality of disability examinations and enhance the level of consistency of disability evaluations. Improvements in these processes will contribute to the overall timely delivery of disability rating decisions and awards, and improve the quality of rating decisions.

Training and Performance Support Systems (TPSS)

The Training and Performance Support Systems (TPSS) developed by the Veterans Benefits Administration (VBA) have two categories of products. Each category directly supports claims processing, but in different ways, as described below:

Training.—Training modules (including performance tests and performance-based tests) train employees to perform critical claims processing tasks, such as "Rate an original claim for compensation." The specific benefit to claims processing is that the training produces, in a relatively short time frame, a highly trained employee who has passed performance tests and is known to be ready to perform the job.

Performance Support.—Job aids and Electronic Performance Support Systems (EPSS) are tools that are used by both newly trained employees and by experienced employees to perform critical claims processing tasks, such as "Process claims for helpless child benefits." These tools include work flows, medical information, and other key data. In general terms, the benefits are that the products increase employees' consistency and efficiency in doing their work by reducing the time required to research necessary information and prepare decisions and letters.

RESEARCH FUNDING

Question. VA anticipates very large increases in the amount of non-VA Federal and private funding for VA researchers, $60 million and $50 million, respectively, a 14 percent increase in non-VA sources. Why the sharp increase next year when you only anticipate a 4 percent increase this year? Is it really appropriate to put the VA in a position of depending on other agencies or the private sector to fund research important to veterans?

Answer. VA based the estimate on actual previous year growth rates, which have averaged approximately 16 percent. Earlier estimates had been somewhat conservative and underestimated actual increases.

In the months since VHA developed the estimates, two underlying assumptions have changed. VA will not receive NIH reimbursement for the indirect facility costs of conducting NIH-funded research, an amount estimated to be $50 million. In addition, NIH budget growth will be lower than expected, resulting in less growth in direct dollars from that organization.

VA believes that funding for research should be a partnership between VA, other Federal research institutions, the medical and drug industry, and institutions of higher learning. Through this type of leveraged partnership of ideas and funding our veterans and society will best be able to reap the benefit of VA's direct investment in research. VA will continue to uses its appropriated dollars to ensure that the research most vital to veterans is funded. The Medical and Prosthetics Research budget provides the resources for VA's multi-site clinical trials, centers of excellence, and other initiatives that have dramatically increased the quality of health care while reducing patient costs. Moreover, appropriated funds provide the research core that enables our investigators to receive so much non-VA funding.

Question. If VA research is funded at the requested level, what areas of research will be cut?

Answer. All currently funded projects will continue, but VA will have to reduce the number of new projects funded in fiscal year 2005 by approximately 120 or 35 percent. No specific areas of research will be cut. Under the proposed budget, VA will be forced to lower the priority cut-off score to 12 instead of a priority score of 18.5 used this year, causing VA to fund a smaller portion of the relevant and scientifically rigorous proposals.

Question. If provided with additional funding, what areas of research would VA add or expand?

Answer. An increase of $65 million in direct research funding would allow VA to expand its research portfolio above the fiscal year 2004 level. In particular, VA would be able to expand research into innovative new approaches to limb loss, prosthetics and tissue replacement for severely wounded veterans returning from Iraq and Afghanistan.

VA/DOD CONCURRENT DISABILITY PAYMENT AND COMBAT-RELATED SPECIAL COMPENSATION

Question. To what extent is the Department of Veterans Affairs (VA) working with Department of Defense (DOD) to implement the concurrent disability payment and combat-related special compensation (CRSC) programs?

Answer. The coordination and support VA provides to DOD for Concurrent Retired and Disability Pay (CRDP), or "concurrent receipt", is primarily in the area of data sharing. The military service finance centers, DOD, Coast Guard, and Public Health Service provide VA with monthly recertification tapes of all retirees verified to be eligible to receive CRDP. VA updates the tapes by annotating any changes in the combined disability evaluation, individual unemployability indicator, rate of compensation, and effective date of change. VA and these payment centers are having ongoing discussions on ways to improve the process. One result of this exchange is that VA has clearly identified the data needs of the military payment centers in the development of the VETSNET application.

VA coordination and support provided to DOD for the combat-related special compensation (CRSC) program include the following major activities:

—VA has contracted with a vendor to image pertinent records from VA claims folders to assist CRSC boards in making their determinations. As of April 1, 2004, almost 6,700 requests for records have been centrally requested under the contract.

—Local regional offices have copied records for hundreds of individual retirees to assist them in completing their applications.

—Remote access to VA's benefits systems has been provided to DOD Boards and is being provided to the Coast Guard and Public Health Service.

—The VA Compensation and Pension Service has provided several training sessions, beginning with an initial 3-day session to Board members to assist them in understanding our data systems and the records being provided to them. VA has conducted additional training on issues such as special monthly compensation and individual unemployability. The staff also provides data on specific retiree claimants in emergency situations, and provides assistance to specific Boards when they have questions.

—VA provides on-going data exchanges on disability evaluations and effective dates of any changes for all disabilities.

—VA has identified the needs of DOD for administering CRSC. These needs will be addressed as VETSNET progresses to ensure that there is no disruption in the information flow when conversion to VETSNET is underway.

QUESTIONS SUBMITTED BY SENATOR PETE V. DOMENICI

TELEHEALTH

Question. Mr. Secretary, as you know, I have long been interested in providing enhanced access to medical care for our rural veterans.

Establishing more community based outpatient clinics is one way Congress and the VA have worked together to reach out to rural veterans. In fact, my home State of New Mexico now operates 11 such clinics for rural veterans.

I believe Congress and the VA should also work together to improve the use of technology for serving rural veterans. In particular, I believe we can do much more in the area of telehealth and telemedicine for disease management and enhanced care for veterans in remote areas.

What is the current state of VA's telehealth program?

Answer. VA is recognized as a leader in the field of telehealth. VHA previous Telemedicine Strategic Healthcare Group has been incorporated into a new Office of Care Coordination (OCC) and the term telehealth is increasingly being used in VHA rather than telemedicine. These changes recognize that implementing telehealth is more than a technology issue it involves embedding telehealth and other associated technologies directly into the health care delivery process and that it now involves many different professionals. VA is undertaking telehealth in 31 different areas. OCC is supporting all these areas but particularly focusing on those where there is particular need and is therefore designating lead clinicians in the areas of telemental health, telerehabilitation, and telesurgery. VA is formalizing guidance for the development of telehealth, with a particular emphasis on the community based outpatient clinic in relation to major areas of veteran patient need. This has commenced with:

—Tele-mental health
—Teledermatology
—Telesurgery (enabling remote pre-op and post-op assessments)
—Teleretinal Imaging for diabetic retinopathy
—Telerehabilitation

Teleradiology is a major associated area of need where VA is seeking to work to bring resources at a local level into an interoperable infrastructure and create a national system. Such a system, if developed, will enable sharing of resources and acquisition of services when local difficulties with recruitment and retention of radiologists create challenges to delivering this care. OCC is working to support VHA's Chief Consultant for Diagnostic Services in this endeavor and to make sure that the various areas of telehealth practice harmonize with respect to important processes e.g., credentialing and privileging. This will facilitate working with the Department of Defense.

Care coordination in VA involves the use of innovative technologies such as telehealth, disease management, and health informatics to enhance and extend care. VA is implementing a national care coordination program that heralds a marked expansion in telehealth across the system.

In recognition of the demographics of the veteran population and the rural and underserved areas in which veteran patients often live VA is placing a particular emphasis on developing care coordination that uses home telehealth technologies. The rationale for this program is to support the independent living of veterans with chronic diseases through monitoring of vital signs at home e.g., pulse, blood pressure, etc. at home. A piloting of this care coordination/home telehealth (CCHT) program demonstrated very high levels of patient satisfaction and reduced the need for unnecessary clinic admissions and hospitalizations. For example, by monitoring a heart failure patient at home it is possible to detect any worsening of the condition when there is breathlessness and weight gain. Early detection in this way means medication can be adjusted and the problem resolved rather than have the patient deteriorate unnoticed and require admission to hospital in extremis at risk of dying, and often necessitating an intensive care unit admission.

VA is creating a national infrastructure to support the safe, effective, and cost-effective use of home-telehealth technologies by veteran patients wherever they reside.

Because the support of a patient at home usually requires a caregiver in the home OCC is paying attention to caregiver issues and working on this collaboratively with other organizations and agencies, as appropriate.

Question. What legislative initiatives would you recommend to improve both telehealth and telemedicine programs?

Answer. At this time we have no specific legislative proposals to recommend.

Question. It is my understanding that VA is implementing a telehealth pilot project to provide medical services to veterans in remote parts of eastern New Mexico. Can you describe how the pilot will be implemented and how it will help our veterans receive better care?

Answer. VA is implementing a telehealth pilot to provide medical services to patients in remote parts of VISN 18. Telehealth is remote patient case management using devices located in the patient's home that connect to hospital staff via a normal phone line. The patient responds to short, disease-specific questions each day. The devices may also be used to transmit vital signs and medical information to hospital staff monitoring the daily reports. Hospital staff can send patients reminders, tips, and feedback on their progress. Telehealth enhances veteran health care because it allows for earlier intervention and enhanced veteran self-care and self-assurance. To begin, selected patients with congestive heart failure and chronic obstructive pulmonary disease will receive telehealth care in their homes. Now that VA Central Office has released equipment funding and equipment can be contracted for, implementation will begin with the Geriatric Clinic and the Spinal Cord Injury Clinic in Tucson, Arizona, followed by their Primary and Medical Care teams. Then the pilot will be expanded to Amarillo VA Health Care System patients. Amarillo will start enrolling medical center patients with congestive heart failure and chronic obstructive pulmonary disease for care coordination in Phase One. When this is operational, Phase Two will begin to enroll patients with these same diseases at the Clovis, New Mexico, and Lubbock, Texas, community based outpatient clinics. VA anticipates that Phase Two will occur in fiscal year 2005.

Question. Are telehealth and telemedicine programs being designed to allow for participation by joint venture partners such as the Department of Defense?

Answer. VA has explored, and will continue to explore, all opportunities to partner with the Department of Defense and other Federal agencies as it develops its telemedicine and telehealth programs. This is important to patients, maximizes the return on Federal investments in technology, and enables standards to be set in this emerging area of technology.

VHA's partnerships with DOD include:

—The AHFCAN program in Alaska (a congressionally mandated cross Federal program),

—The Telemedicine Hui in Hawaii (a congressionally mandated cross Federal program),

—Teleradiology with the Navy at Great Lakes Naval Recruiting Station in Chicago,

—Teleretinal imaging for diabetes care in Boston, Maine and Hawaii,

—Developing credentialing and privileging standards for telemedicine/telehealth that were used by the Joint Commission for Health Care Organizations in formulating their standards in this area.

To foster possible VA/DOD collaborations VA regularly engages with DOD telemedicine/telehealth colleagues at:

—An inter-service DOD working group on telehealth that VHA attends Telehealth Working Integrated Project Team (TH W–IPT),

—The Joint Working Group on Telehealth—a cross-Federal group that VA and DOD both participate in,

—VA and DOD participation at the American Telemedicine Association industry briefings each fall.

As a recent example of VA/DOD collaboration, on February 12, 2004, VA presented a satellite broadcast on telesurgery to VA clinicians nationwide in partnership with the U.S. Army's Telemedicine and Advanced Technologies Research Center (TATRC). VA's chief of surgery is currently working with TATRC on joint developments involving telesurgery.

MEDICAL RESEARCH

Question. Investments in research projects at VA have led to a number of promising advances in our understanding of diseases and medical conditions. These include breakthroughs in areas such as spinal cord and prosthetic research.

Can you describe some of the current trends in VA medical research and tell us where we might expect some new breakthroughs in the near future?

Answer. VA continues to maintain strong research portfolios in its core competencies. These include mental health, clinical trials, substance abuse, spinal cord injuries, and Post-Traumatic Stress Disorder (PTSD). In addition, VA is placing increased emphasis on prosthetics and rehabilitation for survivors of combat trauma wounds, Gulf War Illnesses and other deployment health issues, vaccine development, and responses to emerging pathogens.

While new breakthroughs are difficult to predict, VA is excited about several promising developments. An ongoing Cooperative Studies Program (CSP) clinical trial using deep brain stimulation offers great hope for those suffering from Parkinson's disease. The study is comparing best medical therapy to deep brain stimulation for improving motor symptoms as well as determining the optimum brain area to stimulate.

Another multi-site trial is examining whether intensified blood-sugar control and management reduces major vascular complications that lead to most deaths, illnesses, and treatment costs for type II diabetic patients. If successful, the study would lead to quality of life improvements to all type II diabetic patients as well as significant cost reductions to VA, Medicare, and other health care organizations.

An upcoming Amyotrophic Lateral Sclerosis (ALS) trial will test the effectiveness of two butyrate compounds in reducing and retarding the devastating affects of the disease. Research involving animal models has shown the ability of both compounds to slow the progression of ALS and improve quality of life. Currently, the most effective ALS medication prolongs life approximately 4 months without providing significant quality of life improvements.

Question. Please talk about how VA's collaboration in medical research with other government agencies and universities is improving the quality of life of our veterans.

Answer. Collaboration with other agencies and organizations has contributed greatly to the effectiveness of VA's research program. VA investigators annually receive research grants from non-VA sources totaling more than $700 million, supplementing the Medical and Prosthetic Research and Medical Care appropriations. These funds permit VA to address better the many conditions affecting the veteran population.

Collaborative efforts permit VA to access the expertise and skills of non-VA researchers at other government agencies and universities. These collaborations benefit both VA and its partners by maximizing intellectual and budgetary economies of scale. In particular, VA is collaborating with the National Institutes of Health on a variety of clinical trials that address many conditions.

COMMUNITY BASED OUTPATIENT CLINICS

Question. Mr. Secretary, veterans from rural States continue to benefit from the use of community-based outpatient clinics.

Occasionally, however, we hear concern from rural veterans about a lack of adequate numbers of medical staff at these clinics.

Please describe what steps VA is taking to address staffing shortfalls that exist at rural clinics.

Answer. Given the variation in increased workload around the system, many sites are experiencing an increase in demand for services. This may result in increasing waiting times and veterans waiting for their first appointment to primary care. Efforts to address staffing shortfalls, as well as the increased wait times that they may engender, include the following initiatives:

—incorporating Advanced Clinic Access concepts;
—hiring new providers when available in the local community;
—recruiting additional providers;
—contracting/fee basis care;
—continued education of clerks to avoid scheduling errors;
—expanding CBOC contracts;
—improving consult management;
—establishing nurse-directed, pre-screening clinics for new patients;
—maximizing clinic scheduling efficiency;
—increasing access to specialists through telemedicine; and
—reviewing data and feedback of data to providers.

Question. What incentives does the VA provide or could it provide to recruit health professionals to rural areas?

Answer. VA is currently awaiting action on the Physician Pay Bill, which would allow VA to be more competitive in the market for recruiting physicians to work within VA. This is especially true for specialty physicians which VA has difficulty recruiting. VA also has before Congress a legislative proposal allowing enhanced flexibility in scheduling tours of duty for registered nurses. The ability to offer compensation, employment benefits, and working conditions comparable to those available in their community is critical to our ability to recruit and retain nurses, particularly in highly competitive labor markets and for hard-to-fill specialty assignments.

QUESTIONS SUBMITTED BY SENATOR ROBERT C. BYRD

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) REPORT PROCESS

Question. Secretary Principi, according to the VA Congressional Liaison Office this past February, you were expected to make a decision on the CARES Commission's recommendations within 30 days of your receipt of the CARES report on February 13, 2004. Further, according to the Federal Register of August 20, 2003, you will either accept or reject the Commission's recommendations, without modification, although Chapter 1 of the CARES report indicates that you could also decide to ask for additional information. Obviously, your goal of making a decision within 30 days of your receipt of the CARES report has been not been met.

When will you be making a decision on the CARES Commission's report? Are you currently seeking additional information on specific recommendations contained in the report? If so, please identify the specific recommendations for which you are seeking more information.

Answer. My decision was released May 7, 2004. I sought no additional information on specific recommendations of the CARES Commission.

Question. Is it your intent to either accept or reject the Commission's recommendation, without modification, in accordance with the Federal Register?

Answer. I have formally accepted the CARES Commission Report although I will use the flexibility it provides to minimize the effect of any campus or service realignment on continuity of care to veterans.

Question. If you reject the CARES Commission's report, how will the vast data and information collected over a several year period for preparation of the CARES report be utilized?

Answer. These data will form the foundation for addition data collection and analysis as the Department proceeds to implement the decisions reached in my decision document.

Question. If you approve the CARES Commission's report, I understand that VISNs will prepare detailed implementation plans and submit them to the Secretary for approval, and then, later these will be refined and integrated into the annual VA strategic planning cycle. What is projected timeline for these activities based in fiscal years?

Answer. In general, the implementation plans will be incorporated into the 2005 Budget Cycle and the 2006 and beyond Strategic Planning Cycle.

CARES REPORT: WARS IN AFGHANISTAN AND IRAQ

Question. Secretary Principi, the CARES process began in October 2000. Since then, the United States has become involved in wars in Afghanistan and Iraq, with hundreds of thousands of troops deployed overseas to participate in combat operations. In Iraq alone, more than 3,000 Americans have been wounded. An unknown number of these troops will require long-term medical care from the Department of Veterans Affairs.

The conduct of these two wars, which could yet extend for years to come, is creating hundreds of thousands of new veterans, all of whom will have some claim to service through the VA health care system.

Secretary Principi, does the CARES process, which started before the United States became involved in an open-ended war on terrorism and a lengthy occupation of Iraq, anticipate providing services to these hundreds of thousands of new veterans? Could there be a need to revise the findings of the CARES Commission to accommodate these new veterans?

Answer. I do not believe that the findings of the CARES Commission need revision to accommodate these veterans needs. At this time we believe that we can accommodate the needs of returning OIF and OEF veterans with the current resources of the VA health care system. However, we will continually monitor our resources in this regard to ensure that we do not fall short in providing them needed health care.

CARES REPORT: OUTSOURCING OF INPATIENT SERVICES AT THE BECKLEY VAMC

Question. I, along with my colleagues, Senator Rockefeller and Congressman Rahall, sent you the attached February 26, 2004, letter asking you to reject the CARES Commission's recommendation to eliminate the 40 hospital beds at the Beckley VA Medical Center. The recommendation, if approved, would require the 15,000 veterans who are enrolled to receive care at the Beckley VA Medical Center to either have their medical care contracted to 1 of 11 hospitals within an hour of Beckley or to travel to the nearest VA hospitals in Salem, North Carolina, and Richmond, Virginia. I received your response on March 24, 2004, which did not address

any of the issues we raised. I continue to be very concerned about the CARES Commission's recommendation pertaining to inpatient services at the Beckley VA Medical Center, and I would appreciate your specific responses to the questions posed below.

Did the Commission contact each of the 11 accredited hospitals that the VA identified as alternatives to verify their ability to absorb the VA patients of the Beckley VAMC? If so, please provide the response of each hospital. If not, please contact them and provide their responses to me and to this subcommittee.

Answer. The CARES Commission did not contact the community alternatives within 60 minutes of the Beckley VA Medical Center, as listed in Appendix D of the Commission's Report. The Commission identified and reviewed available data for alternative community resources for every VA medical center identified in the DNCP as a small facility. As part of that review, data indicated the types of services offered by the community resource, the number of staffed beds for the services, and the average daily census for those beds.

The CARES Commission's charter expired on February 29, 2004. Should the Secretary accept the Commission's recommendation to discontinue services at a VA medical center, the Commission believes that the implementation and operational strategic planning processes would include collaborating and negotiating with community facilities to provide alternative medical care to veterans.

Question. What considerations were given to the long and many times treacherous travel that elderly veterans who would normally rely on the Beckley VAMC for inpatient services will have to travel to reach Salem, North Carolina, or Richmond, Virginia, which is at least a 4-hour drive from Beckley?

Answer. After due consideration, I have not found it reasonable to consider the closure of the inpatient medical beds at the Beckley VAMC for the foreseeable future.

Question. What specific cost savings does outsourcing outpatient care from the Beckley VAMC to local hospitals offer?

Answer. Outsourcing outpatient care was never a part of the small facility plan for Beckley, nor did the CARES Commission recommend it. In fact, the Commission recommended that Beckley retain its multi-specialty outpatient services. I concurred with this recommendation.

CATEGORY 8 VETERANS

Question. The administration suspended new enrollments of Category 8 veterans in January 2003. This means that veterans with higher incomes that do not have a service-connected disability may be denied service at VA hospitals, contrary to the intent of the Veterans Health Care Eligibility Reform Act of 1996.

Secretary Principi, how much of an increase in VA health care funds would be needed to resume enrollments of Category 8 veterans?

Answer. VA has determined that resumption of enrollment for Priority 8 veterans would require an additional $519 million in fiscal year 2005, growing to an estimated $2.3 billion in fiscal year 2012.

Question. For how long does the administration anticipate rejecting new enrollments of Category 8 veterans?

Answer. At this time, we are unable to project how long VA will continue the policy of not accepting the enrollment of new Priority 8 veterans.

The statute governing VA's enrollment system requires the Secretary to decide annually whether VA has adequate resources to provide timely health care of an acceptable quality for all enrolled veterans. Each year, VA reviews actuarial projections of the expected demand for VA health care in light of the expected budgetary resources and develops necessary policies to manage the system of annual patient enrollment. VA has not made a decision regarding reopening Priority 8 enrollment in fiscal year 2005, but will do so later this year. We must consider not only the impact of this policy in fiscal year 2005, but also the impact in future years.

Question. Does the CARES Commission report anticipate that the suspension of new Category 8 enrollees will continue?

Answer. The CARES Commission report assumed a continuation of the suspension of enrollment of new Priority 8 veterans.

SUBCOMMITTEE RECESS

Senator BOND. Thank you very much, Mr. Secretary.

Secretary PRINCIPI. Thank you, Mr. Chairman. It is always a pleasure.

Senator BOND. We appreciate the discussions. I think they were very constructive.

The hearing is recessed.

[Whereupon, at 3:47 p.m., Tuesday, April 6, the subcommittee was recessed, to reconvene subject to the call of the Chair.]